Religious issues in ethnic minority mental health with special reference to schizophrenia in Afro-Caribbeans in Britain: a systematic review.
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Background

Religion and mental health

How does religion affect mental health?

By about ten years ago, there was some consensus that there was an overall positive association between the two. Underlying this, there are many effects to consider, many aspects of religion, and many aspects of mental health. The last decade has seen a mushroom-like growth of studies and reviews (see Loewenthal, 1995; Bhugra, 1996; Worthington, Kurusu, McCullough & Sandage, 1996). There is scope for methodological improvements, and many interesting questions to be answered. This review is concerned with one set of such questions: religion and mental health among Afro-Caribbeans particularly those living in the UK and the USA, with particular reference to schizophrenia.

Definition of "Afro-Caribbean" and scope of research in this review.

The Hutchinson Encyclopaedia defines an Afro-Caribbean as a "West Indian person of African descent", and adds that Afro-Caribbeans are descended from West Africans captured, or bought from African traders by Europeans, who shipped them to European colonies in the West Indies from the C16th onwards, until the abolition of slavery which occurred in different countries and colonies at different points in the C19th. Since World War II many Afro-Caribbeans have migrated to the UK, the USA and the Netherlands.

There seems to be little or no research material on mental

illness on Afro-Caribbeans in the Netherlands, but there is a great deal on Afro- (or African-) Americans, and on Afro-Caribbeans in the UK, who are mostly descendants of West African slaves shipped to North American colonies, or immigrants from the West Indies.

While it is agreed that Afro-Caribbeans in Britain and Afro-Americans in the USA have many similarities in their history and current circumstances, we have not used the terms inter-changeably. We have drawn on research material from both Afro-Caribbeans in Britain and Afro-Americans, as well as on people of African descent in the Caribbean area, in Africa, and occasionally elsewhere.

Schizophrenia among Afro-Caribbeans.

This review focuses on one specific set of questions: how might religion affect the reported over-representation of Afro-Caribbean groups among those diagnosed with schizophrenia in the United Kingdom? Possibly related problems are the greater use of compulsory detention under the 1959 Mental Health Act, including police involvement in hospitalization, and the use of restraint and pharmacological agents in control of Afro-Caribbean patients. Such over-representation also exists of Afro-Americans in the USA, and is by comparison both with other ethnic groups in the UK and the USA, and also with Afro-Caribbeans in African and Caribbean countries, where there has perhaps been a less marked degree of recent disadvantage and minority status (Davis, 1975; Ineichen, 1986, 1991; Cope, 1989; Thomas, Stone, Osborn & Thomas, 1993). Sugarman & Craufurd (1994) have concluded that the very high morbidity risk for schizophrenia among British Afro-Caribbeans is entirely due to environmental (not genetic) factors.

An interesting claim has been made by Littlewood & Lipsedge (1978, 1981a, 1981b), and others. Littlewood & Lipsedge based

their claim on a series of studies of patients admitted with diagnoses of psychosis to a psychiatric hospital in East London. They suggest that the high rates of psychosis among Afro-Caribbeans are explained by rates of schizophrenia similar to those in other ethnic groups, plus rates based on a large number of acute psychotic reactions with paranoid and religious flavour. These latter disorders are diagnosed as schizophrenia, but resemble acute psychotic disorders described in Africa and the Caribbean, and have a sudden onset with a clear provoking agent. Littlewood & Lipsedge's patients were first-generation immigrants. Littlewood & Lipsedge's suggestions deserve further attention, particularly with regard to forms of psychosis in second-generation Afro-Caribbean immigrants, among whom rates of psychosis are reported to be even higher than in the immigrating generation. There has been no comparable work in the USA.

This review takes up the more general but related issue of the ways in which psychosis in Afro-Caribbeans may be affected by religious factors.

Social history

Afro-Caribbean social history in Britain and USA is dominated by the hideous history of slavery. European slave-traders were buying slaves from the West Coast of Africa in increasing numbers during the seventeenth and eighteenth century, particularly to provide labour for plantation development in the New World (the Caribbean and the Americas), recently colonised by European settlers. The native Indian populations were severely reduced, by desettlement, genocide and European-imported illnesses, and African slaves were a readily-available source of cheap labour for the sugar plantations. Increasing numbers of people from West Africa were kidnapped and sold into slavery, and transported across the Atlantic in horrible conditions of cruelty, filth and disease. Altogether an estimated 10 million Africans were brought to the New World in this way, mostly to the Caribbean area (Curtin, 1969). In the

plantations, any family and social networks which had survived kidnapping and transportation were broken up, and the practice of native religion disallowed (Goveia, 1965). This was coupled with cruel retribution for anything other than passive obedience, engendering disorientation, helplessness, and dependence. The abolition of slavery in Europe, the Americas and the Caribbean led to some improvement in social and economic conditions, but these improvements were generally small and the social and psychological legacies of deracination and cruelty remained (Wagley, 1961; Franklin & Moss, 1988). Economic need resulted in steady migration to the Northern United States, and a flood of immigration from the Caribbean to Britain in the 1950s and 1960s. Afro-Caribbeans continue to be beset by racism, exploitation in employment, lack of opportunity, and other forms of social and economic disadvantage in both the UK (Rack, 1988) and the USA, although there have been legislative attempts to remove some of these disadvantages (Franklin & Moss, 1988; Jackson, 1991).

Religion in Afro-Caribbean life.

Afro-Caribbean religion is said to embody responses to oppression and exploitation, enabling the expression of spirituality (Baer, 1984; Griffith & Bility, 1996), the formation of communitas (Turner, 1969) and hence social support and identity. The two dominant strands have been native African religions, and European Christianity. The former was suppressed, and the latter imposed upon the plantation slaves and, later, encouraged by missionaries to the freed slaves (Gates, 1980; Brewer, 1988; Chatfield, 1989). The current situation involves a huge range of often syncretistic blends, although the African elements are less overt in British and US black-led Christianity than they are in the Caribbean and its neighbourhood, and in Africa.

New black religious movements include Black Islam (Franklin & Moss, 1988; McCloud, 1995) in the USA, and Rastafarianism

(Hickling & Griffith, 1994) in the Caribbean and the UK. However in the UK and the USA the dominant form of black religion is Christianity with African influences (Jules-Rosette, 1980). Howard (1987) concluded that post World War II Caribbean Christian immigrants to the UK expected a warm welcome from the existing churches, but found them cold and unfriendly, and so set up their own groups. Most Christian Afro-Caribbeans in the UK are now reported to be affiliated to black-led churches, with predominantly black membership. The most popular forms are charismatic and pentecostal Christianity, and Seventh Day Adventists. Howard does not offer figures, but of Cochrane & Howell's (1993) random community sample of black men in the UK Midlands, 27% belonged to generally white-led churches (Church of England, Roman Catholic), 52% were Pentecostal (almost or completely black-led), and 4% were Rastafarian (with 18% non-affiliated). Leadership in black-led churches is generally strong and respected, since religious leaders have emerged by force of personality, charisma, popularity and dedication to the needs of their communities. There is emphasis on enthusiastic prayer, which may include the gift of speaking in tongues, dance, and trance-like possession states, and on living a moral, family-centred life, with good physical health practices, and kindness and helpfulness to others (Howard, 1987). Griffith (1980) provides a valuable description of a week-night service in a pentecostal group in the USA. The service includes extensive and enthusiastic thanks and praise to the Lord for healing and support, as well as the features described above (speaking in tongues etc.). Healing may be an important religious activity, and services in black-led churches are reported by their participants to be emotionally and spiritually positive experiences (Griffith & Mathewson, 1981; Griffith, Young & Smith, 1984; Maloney & Lovekin, 1985).

Afro-Caribbean "counter-culture" is said to emphasise partying, promiscuity, drink and drugs (Howard, 1987), but Cochrane & Howell's figures suggest that members of this counter-culture may be a minority among Afro-Caribbeans.

Religiously, the situations in the USA and the UK are somewhat similar, although that the black-led churches in the USA have a longer history than those in Britain, dating from the latter half of the C19th (Franklin & Moss, 1988). Those in Britain date mainly from the post World War II period.

In contemporary religious life in Africa, the Caribbean, and in black communities in Central and South America, the influence of traditional African religions is more overt, and the social-scientific and medical literature shows many examples of traditional African practices relating to health and mental health, some of which will be described in this review.

Definitions of religion

There is a variety of definitions and measures of religion (Brown, 1987). Loewenthal (1995) suggests that religion involves belief in spirituality, a divinely-based moral code, and seeing the purpose of life as increasing harmony in the world by doing good and avoiding evil. All religions involve and depend on social organisation for communication of these ideas. Glock & Stark (1965) suggested five possibly orthogonal aspects of religiosity: experiential, ritual, belief, intellectual, and a fifth dimension reflecting the extent to which the first four are actually applied in daily life. In practice, four popular measures of religiosity are: affiliation, self-definition (as religious), practice (attendance, prayer and other activities), and belief.

Definition of schizophrenia

(Source: DSM-IIIR, American Psychiatric Association, 1987):
* no major mood changes (i.e. not depressed or elated), and
* no evidence of organic causes (eg drugs, illness, injury), and
* continuous signs of disturbance of 6+ months, and
* deterioration in self-care, work or social relations, and

* for at least a week, two of: delusions, prominent hallucinations, incoherence or bizarre speech, catatonic behaviour (immobile, unresponsive), inappropriate or no emotional responsiveness, or, one of: bizarre delusions (eg. thoughts are being broadcast on TV), prominent hallucinations of a voice.

Search strategy

The search strategy was based on some of the guidelines indicated by the UK Cochrane Centre National Health Service Research & Development Programme (Chalmers & Haynes, 1994; Eysenck, 1994; Knipschild, 1994; Mulrow, 1994; and particularly Oxman, 1994), and by the York University National Health Service Centre for Reviews and Dissemination (1996). These guidelines suggest selecting clinical trials teaching certain standards of research design. The number of such studies in the field under review was negligible, and meta-analytic work was therefore impossible. However the guidelines were followed insofar as search terms and search strategies were defined. These were as follows:

The central problem has been defined as religious issues in schizophrenia among Afro-Caribbeans.

Three groups of search terms were used (where acceptable, the suffix * or ? followed a truncated form of words such as religious, religiosity, religion: i.e. relig* or relig? Otherwise the alternatives were spelled out):

Group 1 (religion)

Relig*
Faith
Belief*
Pentecostal*

Adventist

Group 2 (ethnicity)

Afr*
Carib*
Black
West (W) Indian
Jamaica
Trinidad
Ethnic*

Group 3 (mental health, schizophrenia, and religious behaviour which might be seen as symptomatic of disturbance)

Mental*
Schizophren*
Possession
Hallucination
Glossolalia
Trance

For electronic databases of articles, books and thesis abstracts, three groups were first formed by searching for any of the search terms in the group. The final search was for material which included at least one search term from each group.

For databases of book titles and theses (which yielded very little using the above strategy), searches were also made by combining search terms from two groups at a time: e.g. relig* afr*, relig* carib*, relig* black etc.

Sources searched

Electronic databases of published articles: Sociofile, Medline, ERIC, Embase, Pascal, PsychLit, BIDS (Social Sciences, Sciences,

and Arts & Humanities). In each case the search was made from the earliest year represented in the database up to the most recent; PsychLit contains articles back to 1972, but the other databases start in or around 1982.

Electronic databases of published books: PsychLit, CUPAC, Libertas, BIDS(check). As with databases of articles, the search was made from the earliest year represented in the database.

Electronic sources of unpublished material: theses (Dissertation Abstracts International (1982-1996), AsLib (British M.Phil. and Ph.D. theses) (1970-1992), and WWW.

Other sources: information about ongoing work was obtained by personal contact including conference attendance, by correspondence, and via WWW.

The main product of these searches was in the form of titles, author and abstract (or book chapters). This first crop was sifted for relevance, and some items immediately discarded. Others were sorted into two categories:

a: of some relevance but no further information needed; some items were subsequently discarded as work proceeded.
b: relevant and original book or article needed. In this latter case the item was either obtained immediately (where available), or via the inter-library loan service. Visual searches were made of the bibliographies of the most fundamental of these books and articles: Griffith (1980); Littlewood & Lipsedge (1981a, 1981b, 1989); Worthington et al (1996); Bhugra (1996).

Conceptual approach

The structure of the review that follows two approaches. Firstly we look at pathways into illness (influences on prevalence), using a broad conceptual framework based on Brown & Harris (1978, 1989), and which is generally popular in social psychiatric and related work. The framework involves three wide classes of variables:

STRESS (ADVERSITY) - MEDIATORS (BUFFERS) - DISTRESS (& ILLNESS)

We propose to examine the influences of religion within each of these classes. The second approach is to examine pathways into care. We examine how religion may affect:

REFERRAL - DIAGNOSIS - TREATMENT.

The review focuses on schizophrenia in Afro-Caribbean groups, but some related material has been included, on religion and mental health generally, and particularly in Afro-Caribbeans, and on Afro-Caribbean religion, both in relation to healing, and in relation to behaviours which may be religiously sanctioned and adaptive, but which might give rise to mis-diagnosis by psychiatrists and others ignorant of cultural and religious mores.

1. Religious influences on prevalence.

Adversity

Here we consider ways in which religion may affect levels and types of adversity (stress), and ways in which religious factors may moderate the effects of adversity. We consider first the beneficial affects of religious factors, and then the possibility of stress-exacerbating effects of religious factors.

First, then, the question whether religious factors may help to minimise adversity. We are not concerned here with general cultural factors - the economic and social difficulties which may be associated with being Afro-Caribbean.

Loewenthal, Goldblatt, Gorton, Lubitsch, Bicknell, Fellowes & Sowden (1996) suggested that patterns of stress - and therefore possibly distress and illness - differed between traditional religious groups and others, among Europeans. Their main conclusion was that severe, disruptive life-events were less

likely among traditional religious groups. This in turn had an impact on the prevalence of depression. We could not find comparable data for Afro-Caribbeans in Britain, but a study of black Americans (Gary, 1984) led to roughly comparable conclusions. This study involved 451 non-institutionalized black adults in Virginia, and one conclusion was that less religious respondents experienced more stressful life circumstances. Further work is needed to confirm the suggestion that religious groups and beliefs may serve to regulate social relations, lessening the likelihood of some forms of stress.

Finally, an intriguing case study suggests further positive features of religious beliefs on stress. Heligman, Lee & Kramer (1983) reported on an elderly black lady who was able to tolerate major abdominal surgery without analgesia. There was minimal post-operative discomfort. She attributed this to the presence of protective angels. Psychological testing and interviews showed her to be "fully in touch with reality".

The sparse material described so far has thrown up several recurrent and important themes in understanding the roles played by religion in Afro-Caribbean mental health. First, the probable importance of religion to many Afro-Caribbeans. Second, the importance of religiously-encouraged social support networks. And finally, the occurrence of religiously-based beliefs and ideas which might be taken as evidence of psychological disturbance by professional care workers without sufficient knowledge of cultural-religious norms and values.

Moderating effects of religion

Table 1 summarises several studies indicating that compared with other groups in Britain and the USA, religion is a more important value for Afro-Caribbeans.

Table 1

Table 1 is replete with suggestions and evidence that religion is indeed important to Afro-Caribbeans in the UK and to Afro-Americans, both in absolute terms and relative to other groups.

We now turn to evidence on the question whether and how religion has a stress-moderating effect among black people.

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Table 2

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Table 2 tells us nothing directly about schizophrenia, and little about stress-buffering effects of religion, but it does indicate a strong association between religion and various measures of health and mental health: low or absent religiosity is a risk factor for poor (mental) health in black people.

Table 3 summarises evidence on means by which religion may be associated with better mental health among black people.

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Table 3

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Table 3 focuses on three routes by which religion may lower the prevalence of mental illnesses among black people, possibly by mitigating the effects of stress.

First, social support: both church and family support are important to well-being, and family support may be enhanced by church membership. But as with research in other groups, the relations between religion and social support could do with further clarification. Social support is important for recovery and prevention of relapse as well as prevention of initial onset.

Second, worship-related activities have been reported to induce feelings of well-being, comfort and other aspects of positive mood, which are likely to have a beneficial effect on mental health..

Third, religion is associated with social-cognitive factors such as identity, self-esteem and beliefs which can have a positive impact on mood.

In all cases however there is a lack of outcome studies. Additionally we know very little about the relations between the factors described, and schizophrenia, in black people.

We now look at possible adverse effects of religion upon mental health.

Table 4

The important suggestions in table 4 are that belief in a relation between sin or wrongdoing, and suffering, may actually cause symptoms of distress or illness. However, these believes may contain the seeds of cure, insofar as they indicate remedies which may sometimes be effective. A further important effect is that "Western" health professionals with inadequate knowledge of cultural-religious mores may view such beliefs as signs of mental disorder.

We noted that there was no reported evidence that religion plays a role in creating or exacerbating adversity. However, religiously-associated physical/emotional abuse is a possibility that has been suggested - often controversially - among other groups (Capps, 1992) and could be examined in Afro-Caribbeans.

Overall, the weight of evidence and of suggestions is that religion is important to Afro-Caribbeans, is likely to have beneficial effects (overall) in lowering prevalence of mental illnesses, and that these effects operate via a number of routes. We note however that little of the research relates directly to schizophrenia. Research designs are generally observational or correlational or involve the reporting of clinical case material. Further research could focus on

schizophrenia, and involve designs which look at outcome either retrospectively or if possible prospectively.

2a. Religious influences on referral

Having looked at religious influences on the prevalence of schizophrenia (pathways into illness) we now look at pathways into care and/or diagnosis. Sometimes there is genuine overlap in research material bearing on the two problems, in which case we have repeated our citations of the studies concerned.

Table 5

The material in table 5 is rather sparse, but as far as it goes supports the suggestion that religious factors may, for various reasons, discourage black people from seeking help for mental illness from (white) mental health professionals: Afro-Caribbeans may fear that their religious beliefs and values may be misunderstood, they may perceive the mental health professions as ineffective or misguided, they may perceive other (religious) helping agents and activities as more effective, and there may be fear of stigma.

If religious helping agents and activities are seen as effective, what are they? Table 6 summarises some information gained in the USA (table 8 offers comparable information from studies on other black groups).

Table 6

The studies in table 6 offer a relatively high degree of quantification, and suggest a range of religious resources seen by black people (at least, those who are church members) as efficacious for mental health problems.

2b. Religious influences on symptoms/diagnosis

An important theme which has intruded throughout this review is the regrettable tendency of (usually white) mental health professionals to regard a range of religious behaviours and beliefs by black people as symptomatic of mental illness. Sometimes indeed there may be a genuine mental illness and it is difficult for the professional to tell whether say, a religious ecstasy, is pathological or not (e.g. Littlewood & Lipsedge, 1989; Csordas, 1987). Table 7 however gives some cause for concern regarding the risk of over-diagnosis of mental illness, particularly of schizophrenia, in black people with religious "symptoms".

Table 7

Table 7 offers a range of descriptive material suggesting that trance/possession, beliefs in evil spirits and witchcraft, and other forms of religious behaviour and beliefs, are particularly likely among people whose background has been influenced by African religion. It is difficult for professionals to distinguish the genuinely pathological from the culturally alien.

An interesting footnote to table 7 is offered by two studies which suggest the presence and amount of religious symptomatology in schizophrenia is actually unrelated to level of individual religiosity (Littlewood & Lipsedge, 1981b; Arnold, 1993).

2c. Religious and related effects in treatment

Much of the literature of Afro-Caribbean schizophrenia suggests that it is characterized by briefer episodes, faster recovery, and less risk of relapse (Littlewood & Lipsedge, 1981a, 1981b; Stevens, 1987). Here we consider religious influences related to

these effects. These religious influences have been discussed elsewhere in this review: religiously-encouraged social support (Jackson & Birchwood, 1996; and see Table 2), stronger religiosity, treatment preferences for clergy, religious practices including syncretic rituals, trance, possession, glossolalia and prayer for therapeutic purposes (see table 6). An important possibility is that religion influences the form and possibly the occurrence of a "culture-specific" brief psychosis in Afro-Caribbeans, which may not even be a true psychosis in some cases. Even where it is, the prognosis is said to be very good compared to "Western" schizophrenia.

The main thrust of the available evidence is that these religious influences contribute to the better prognosis of Afro-Caribbean schizophrenia. The chief possible adverse effects of religion lie in the risk of misdiagnosis of religious behaviour and beliefs as schizophrenia (see table 7).

We look finally at some more remote religious influences on Afro-Caribbean mental illness and its cures.

Table 8

Table 8 shows a range of overtly African-influenced religious practices and beliefs related to mental illness. Although it has been stressed that this kind of information needs to be taken on board by mental health professionals working with black people, there have been no outcome studies in this area.

The use of culture-sensitive, collaborative, multicultural approaches have been advocated in various ways. Views that black people need to weaned away from "unscientific" beliefs in religious factors now seem out-moded in the face of a two-pronged attack - in one direction from those favouring multicultural approaches in medicine and psychiatry, and in the other direction from an increasing body of scientific evidence

that religious factors may play important preventive and therapeutic roles in mental illness. Several postures on multiculturalism have been outlined (MacLachlan, in press); most authors report that Western-trained professionals are pragmatically taking into account other ("non-Western") beliefs, and where indicated, are referring for treatment which is consistent with those beliefs (Burlew, 1992; Brent & Callwood, 1993; Jackson; 1986; Jones, 1990; Lefley, 1981; Lefley & Bestman, 1977; Richardson, 1991; Sandoval, 1979; Stevenson, 1990).

For example, Csordas (1987) describes several case vignettes from a Brazilian psychiatrist who is an initiated elder of the Afro-Brazilian candomble cult. The cases involved cross-referral from the psychiatrist to religious practitioners, and sometimes back again. Of particular interest in Csordas' account is the psychiatrist's observation that some of the religious practitioners are able to distinguish between a genuine religious trance (called orixa), a simulated one, and a hysterical crisis, a feat which the psychiatrist says is beyond the psychiatrist. In the latter case they will tell the client to see a doctor.

Some mental health practitioners have tried to incorporate aspects of traditional healing into their practice - kind of psychiatric syncretism. However some authors (Oyarebu, 1982) incline to the view that it is wiser for Western and religious forms of healing to co-exist (and cross-refer where necessary).

A careful set of suggestions is made by Maclachlan (in press), who recommends that the clinician should draw up a "problem portrait". This is a description of all the things that are "wrong" with the patient (according to the patient), what s/he thinks caused them, and what s/he thinks other members of their social group/s think cause problems like this. This will enable the clinician to draw up treatment goals in collaboration with the patient, and to draw on healing resources that are seen as

appropriate, often using several different kinds of healing resource and cross-referring where necessary.

Summary and conclusions

What then are the religious influences on schizophrenia among Afro-Caribbeans?

Religion is important to Afro-Caribbeans in the UK and to Afro-Americans, both in absolute terms and relative to other groups. Via a number of routes, religious factors may lower prevalence and improve prognosis. This is a bit speculative because most of the evidence relating religion to mental health among Afro-Caribbeans deals with forms of mental illness other than schizophrenia. Clearly there is space for research on the ways religious factors - social support, worship-related activities and social-cognitive factors - relate to prevalence, referral and recovery in schizophrenia. It is suggested that the direction of these effects is likely to be to lower prevalence and referral, and improve recovery. If so, these effects cannot explain any higher rates of schizophrenia referral among Afro-Caribbeans.

However there is also the suggestion that religious factors may influence symptoms, sometimes causing a risk of over-diagnosis of schizophrenia.

However it is unlikely that the high risk of schizophrenia among Afro-Caribbeans can be explained solely in terms of the added likelihood of "culture-specific" psychosis influenced by cultural-religious factors. If this were so, it would be hard to explain the reported rise in risk of schizophrenia among second-generation immigrants to the UK. Moreover, "culture-specific" psychosis is reported in African countries and elsewhere, where rates of schizophrenia are said to be as low as in indigenous

European and other groups. These phenomena might be better understood with better information on religiosity in relation to schizophrenia.

The only way in way in religious factors are likely to contribute to raised rates of schizophrenia is however in over-diagnosis of schizophrenia among disturbed Afro-Caribbeans presenting with a "religious flavour" to their disturbance. But this is speculative and deserves closer study.

Religious methods of healing are to an increasing extent being taken into account by mental health professionals, including those working among Afro-Caribbean groups. It is likely that this trend will continue. It is to be hoped that outcome studies will appear in this field.

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Table 1: Importance of religion in black compared to white groups, in the USA and in Britain.

Study	Country	Source and type of information	Findings and conclusions
Boyd-Franklin (1989)	USA	Review highlighting five fundamental strengths in black families and implications for treatment.	One strength is "strong religious orientation".
Cochrane & Howell (1995)	UK	200 black 170 white men, random sample.	Similar proportions of blacks (74%) and whites (75%) religiously affiliated, higher proportion of blacks (29%) than whites (9%) attended regularly
Edwards (1987)	USA	25 black adults, (8M 17F), self-defined components of psychological health.	Five essential characteristics of a psychologically healthy Black American: religion and spirituality the most important.
Ellison (1995)	USA	Summary of three major surveys	Average levels of religious engagement are higher among African Americans than among whites
Ferraro & Koch (1994)	USA	National sample (Americans' Changing Lives, 1986)(N=3,497)	Three dimensions of religiosity were strongest among black adults (and women)
Jones (1990)	USA	Review of literature on effectiveness of white therapists treating black clients	Therapists should consider (among other factors) the "intense religious orientations" of black people
Rosen (1982)	USA	Interviews with 148 senior citizens (age over 65)	Blacks used religion to "a greater degree" then did whites, both to cope with adversity and to reduce depression

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Table 2: Evidence of association between general measures of religiosity and mental health in black groups.

Study	Country	Source and type of information	Findings and conclusions
Brown & Gary (1987)	USA	177 black male, 274 black female adults	No direct or buffering effects of religiosity on mental health; religiosity inversely to physical health among females (only)
Brown & Gary (1988)	USA	245 black females, community-based survey	High religiosity (and perceived social support) important in reducing distress, especially in unemployed compared to employed.
Brown & Gary (1994)	USA	537 urban black males	Denominational affiliation associated with fewer depressive symptoms; higher frequency of church attendance associated with less alcohol cigarette consumption.
Cochrane & Howell (1995)	UK	200 black 170 white men, random sample	Religious observance and belonging to a Pentecostal church were strongly associated with moderation in alcohol: alcohol problems among blacks explained by black religiosity.
Ellison (1995)	USA	Community sample N=2956 (1029 black, 1927 white)	Denominational affiliation associated with fewer symptoms among blacks only; frequency of church attendance associated with fewer depressive symptoms among whites only; frequency of private devotion associated with depressive symptoms among blacks and whites. Summarises other work showing importance of religion for good mental outcomes especially among black Americans.

Ferraro & Koch (1994)	USA	National sample (Americans' Changing Lives, 1986)(N=3,497)	The association between religion and health differs for black and white people: social support important for health in both blacks and whites; the religious consolation hypothesis was supported for blacks only, and there was an overall association between religion and health among blacks.
Martin (1984)	USA	US annual suicide rates and church attendance among representative sub-populations	Religiosity (church attendance) associated with lower suicide among both blacks and whites, males and females.
Millet, Sullivan, more Schwebel & Myers (1996)	USA	67 black & 78 white subjects read vignettes on mental health problems, and rated importance of spiritual and other factors as causes, and their effectivesness in treatment.	Black American respondents rated spiritual factors as important in aetiology and treatment than did whites.
Platt (1995)	UK	100 church members (Seventh Day Adventists) and 100 non-members	Religiosity was associated with fewer health and mental health problems (however groups were not closely matched for ethnicity: 79% church members were black; only 37 % non-members).
Taylor & Jackson (1991)	USA	289 urban African-American women	7 variables (including religious orientation) were significantly related to general mental health symptoms.

Table 3: Means by which religion may improve mental health among black groups.

Social support and family

Study	Country	Source and type of information	Findings and conclusions
Boyd-Franklin (1989)	USA	Review highlighting five fundamental strengths in black families and implications for treatment	One strength is "the bond of the extended family".
Brown & Gary (1987) (women	USA	451 urban black adults	Number of near relatives related to mental health (for women); perceived social support buffered effect of stress on mental health only); number of confidants inversely related to physical health (men only)
Caldwell, Greene & Billingsley (1994)	USA	Review of historical material and own research programme	Family support programmes provided by Black churches; nature of provision has changed over time.
Ferraro & Koch (1994)	USA	National sample (Americans' Changing Lives, 1986)(N=3,497)	Social support important for health in black people (and in whites)
Gary (1984)	USA	Probability sample of 451 black adults	Low religiosity, and aspects of low social support (being divorced/separated, not being an active community participant) associated with more stress.
Gary (1985)	USA	Probability sample of 451 black adults	Religion was unrelated to perceived conflict in male -female relationships.
Howard (1987)	UK	Review of studies on Afro-Caribbean Christianity in Britain	Church leaders are emergent, respected for their personal qualities, turned to for advice, offer guidance on matters which may enhance

			family stability e.g. banning extra-marital sex.
Stevenson (1990)	USA	A position paper	Stresses importance of church leadership (in this case, in education about teenage pregnancy)
Walls & Zarit (1991)	USA	98 black elderly people (65-104): interviews.	Family network perceived as more supportive than the church network, but both forms of support contributed to feelings of well-being Involvement with organized religious activities, and spiritual aspects of religion unrelated to well-being.

Worship-related activities

Study	Country	Source and type of information	Findings and conclusions
Ellison (1995)	USA	Community sample, blacks and whites (N=2956)	Frequency of private devotional activity (e.g. prayer) associated with depressive symptoms in both blacks and whites
Griffith (1980)	USA	Observational study of Wednesday night black church service; attendance about 11% of Sunday services, mainly church activists	Thanks to G-d, led by male members, then pastor leads; members give testimony, saying how G-d has helped them cope. Possession/trance states, especially among the women, also glossolalia. Members report feelings of love, warmth and re-birth.
Griffith & Mathewson (1981)	USA	Observational study as described above (Griffith, 1980)	This religious group compared to the "healing community"; involves "communitas" and "healing charisma". It was suggested that improvements in psychiatric status may be "more than transient".
Griffith, Young & Smith (1984)	USA	Interviews with 20 frequent attenders at mid-week services described above (Griffith, 1980) Ages 18-27 years.	Feelings and behaviours in relation to 4 main components of service: testimony - ineffable, religious; possession - ecstasy, relief; dancing

			& glossolalia - religious. As a whole - group closeness, hope, altruism, self-expression, helping others.
Ness & Wintrob (1981)	USA	Description and synthesis of folk healing in the USA	Describes faith healing in fundamentalist Christian groups, and belief in rootwork among black (and white) people in SE USA

Social-cognitive factors: Beliefs and identity.

Study	Country	Source and type of information	Findings and conclusions
Bartocci (1975)	South Africa	33 Bantu and 30 "Coloured" patients, first hospitalization with psychosis	The coloured patients' disorders were more serious (mostly hebephrenic); no solid cultural background. The Bantus background is structured by animalistic beliefs, firmer ego/identity.
Hickling & Griffith (1994)	Jamaica & others	Discussion of clinical perspectives on the Rastafari movement	May provide an affirmation an affirmation of black identity and a moral framework.
Hill (1987)	USA	Observation of Simba Wachanga ceremony; discussion of rearing the African-American child.	Need for coming-of-age (and other) rituals to ensure continuity of culture and cultural identity.
Littlewood (1993)	Trinidad	Medical Anthropological study, case studies.	Discusses relations between pathology and identity.
Gesler & Nahim (1984)	Sierra Leone	200 in-patients 207 out-patients at the only Western mental hospital.	The (more seriously ill) in-patients were less likely to have social support, more likely to express Western ideas about the causes of mental illness, and have more Western treatments than out-patients (possibly suggesting weak identity).

Redlener & Scott (1979)	USA	Case study of 9-month-old black child admitted to hospital with meningitis and brain damage. Mother devout and grandmother an ardent minister of the Holiness Church	Belief in efficacy of prayer and reform by sufferer and his/her social network
Snow (1974)	USA	Interviews with members and ministers of the Holiness Church	Belief in efficacy of prayer and repentance.

Table 4: Means by which religion may have adverse effects on mental health among black groups.

Study	Country	Source and type of information	Findings and conclusions
Belief in sin and suffering			
Redlener & Scott (1979)	USA	Case study of 9-month-old black child admitted to hospital with meningitis and brain damage. Mother devout and grandmother an ardent minister of the Holiness Church	The grandmother believed that the child's serious condition was due to the mother failing to have prayed enough.
Snow (1974)	USA	Interviews with members and ministers of the Holiness Church	Illness can be sent as a punishment for sin; a reminder to improve; children's illness may be the result of parents' sins; a doctor may not be able to heal (as suggested by interviewees).
Littlewood & Lipsedge (1989)	UK	Case study	The patient was self-harming and self-destructive; she had a strictly religious, physically-abusive upbringing, and felt she was irredeemably bad.
Belief in evil or harmful spirits or witchcraft			
Erinosho (1977b)	Nigeria	4 case histories of Nigerian patients undergoing psychotherapy	Belief in the evil machinations of others through witchcraft reported by all. This belief is not confined to the nonliterate.
Lefley & Bestman (1977)	USA & Carib-bean	Description and discussion of psychotherapy in Caribbean cultures	Describes indigenous healing systems: Voudou (Haiti), Obeah or witchcraft (British West Indies, Virgin Islands, Bahamas), Espiritismo (Puerto Rica), Santeria (Cuba).

			Mentions the practice of various forms of hexing
Hillard & Rockwell (1978)	USA	Case study of an intelligent, well-educated black woman suffering from dysesthesia, from the rural Southern USA	The authors suggest that the dysesthesia was a conversion reaction, and it responded to conventional psychotherapy. However the patient believed was the victim of witchcraft. Beliefs in witchcraft (rootwork, hexing) should be inquired about in patients with unusual symptoms and the appropriate cultural background.
Littlewood & Lipsedge (1978, 1981a, 1981b)	UK	Patients admitted with diagnoses of psychosis.	Many Afro-Caribbeans' had a paranoid and religious flavour, resembling "bouffees delirantes" described in the French West Indies, in which the persecutory content is often linked to witchcraft.
Ness & Wintrob (1981)	USA	Description and synthesis of folk healing in the USA	Describes faith healing in fundamentalist Christian groups, and belief in rootwork among black (and white) people in SE USA
Patel (1995)	Africa	Reviews studies of beliefs about the causes of mental illnesses from 11 countries in sub-Saharan Africa.	Causes can include spiritual factors.
Stevens (1987)	Africa	3 case histories	Suggests that belief in witch-craft and fear of ancestor retribution in Africa and developing countries may play a role in acute psychoses.
Ward & Beaubrun	UK	20 members of a West Indian Pentecostal group, 16 women and 4 men, with belief in malevolent spirit possession, tested	The 10 subjects who were defined as spirit-possessed scored significantly higher on neuroticism and hysteria than did the control group. Suggested that possession

neurotic	with the EPI and the hysteria scale of the MMPI.	may be a culture-bound disorder.

Table 5: Religious factors which may discourage black people from consulting orthodox medical and mental health services: Religion seen or used as a more effective form of coping, and religious/social disapproval of use of orthodox services.

Study	Country	Source and type of information	Findings and conclusions
Jones (1992)	USA	Literature review on psychotherapy with African-American women	Spirituality is an important construct and coping strategy within the African-American culture
Lefley & Bestman (1977)	USA & Carib -bean	Description and discussion of psychotherapy in Caribbean cultures and relations with psychotherapy.	Describes indigenous healing systems: Voudou (Haiti), Obeah or witchcraft (British West Indies, Virgin Islands, Bahamas), Espiritismo (Puerto Rica), Santeria (Cuba)
Millet, Sullivan, more Schwebel & Myers (1996)	USA	67 black & 78 white subjects read vignettes on mental health problems, and rated importance of spiritual and other factors as causes, and their effectivesness in treatment.	Black American respondents rated spiritual factors as important in aetiology and treatment than did whites.
Purdy, Simari & Colon (1983)	USA	32 Black and 73 Puerto Rican members of 5 Pentecostal churches. Questionnaire on religion, mental illness, and pastor's role.	The majority of those surveyed would turn to their pastor rather than to a counsellor or clinician for help with personal or family problems.
Redlener & Scott (1979)	USA	Case study of 9-month-old black child admitted to hospital with meningitis and brain damage. Mother devout and grandmother an ardent minister of	The mother and grandmother said that the baby should be removed from hospital so that proper prayers could be started. Grandmother believed that an illness of the mother had been cured by prayer, and

		the Holiness Church	the child's condition would not be so serious if the mother had prayed more.
Silva de Crane & Spielberger	USA	309 18-35-year-old Anglo, Spanish-American & Black undergraduates. Attitudes to mental illness.	Blacks and Hispanics had more negative and less benevolent attitudes to mental illness than whites (suggesting possibly greater degree of stigma.

Table 6: Some forms of coping and treatment reported among black groups in the UK and USA, alternative to orthodox medical and psychological provision.

Study	Country	Source and type of information	Findings and conclusions
Griffith, Young & Smith (1984)	USA	Interviews with 20 regular attenders of a mid-week black church service.	It is suggested that the service is a mental health resource. Features are testimony, possession. dancing and speaking in tongues. Therapeutic factors include hope, group cohesiveness, altruism and helping.
Lefley & Bestman (1977)	USA	Description of mental health needs and provision for Caribbean immigrant groups in Miami	Describes belief in hexing, use of folk healers, and a health which attempts to combine traditional and scientific approaches to psychotherapy.
Mollica, Streets & Boscarino (1986)	USA	Survey of 116 traditional clergy including 21 black clergy.	The black clergy were functioning as a major mental health resource, compared with others, some of whose activities were very limited partly due to the emergence of pastoral counsellors who have largely taken over the counselling functions of clergy among non-blacks.
Purdy, Simari & Colon (1983)	USA	32 Black and 73 Puerto Rican members of 5 Pentecostal churches. Questionnaire on religion, mental illness, and pastor's role.	The majority of those surveyed would turn to their pastor rather than to a counsellor or clinician for help with personal or family problems.

Table 7: Religiously-endorsed/encouraged behaviour which might be regarded as psychotic or otherwise disturbed

Study	Country	Source and type of information	Findings and conclusions
Alonso & Jeffrey (1988)	USA	Four case studies of Cuban American psychiatric patients	It is suggested that (belief in) spirit possession fostered by the syncretic Afro-Christian religion Santeria may have complicated diagnosis and treatment
Ananth (1984)	USA	Case study of a 19-year old black woman who died the day after treatment for sudden psychosis with hyper-religiosity.	Post-mortem showed thymoma. The possibility of an organic cause in patients showing psychosis with hyper religiosity should be considered.
Dobbin (1983)	Mont-serrat, West Indies	Anthropological analysis of ethnographic data on the Jombee dance	The music and steps are European-influenced, but the role of trance-divining, the intervention of ancestor-Jombees (spirits who possess the dancers) and the use of Obeah (magic) indicate African roots.
Early & Lifschutz (1974)	USA	Case study: a 10-year old black girl who experienced religious stigmata (including bleeding), and auditory hallucinations of a religious nature.	There was no evidence of psychopathology
Hickling & Griffith (1994)	Jamaica & others	Discussion of clinical perspectives on the Rastafari movement (includes three case histories).	Beliefs and practices include wearing dreadlocks, sacramental use of marijuana, opposition to traditional government. Clinicians are encouraged to diagnose on phenomenological grounds rather than social behaviour.
Hall (1984) from	USA	Historical analysis of the religious experiences of blacks in Florida 1565-1906	Traces the development of independent black churches the period of slavery (when slaves were relegated to separate pews in white-

			dominated churches). The final chapter focuses on the centrality and persistence of possession-like ritual behaviour over the period studied.
Hillard & Rockwell (1978)	USA	Case study of an intelligent, well-educated black woman suffering from dysesthesia, from the rural Southern USA	The authors suggest that the dysesthesia was a conversion reaction, and it responded to conventional psychotherapy. However the patient believed was the victim of witchcraft. Beliefs in witchcraft (rootwork, hexing) should be inquired about in patients with unusual symptoms and the appropriate cultural background.
Lipsedge (1996)	UK	Medical-historical review of religion and madness, including a number of case histories.	Their is little to support Zilboorg & Henry's (1941) conclusion that madness was widely believed to be caused by possession. A number of cases involving religious phenomenology are examined (holy anorexia, possession, visions, etc) as are the debates regarding whether the sufferer was saintly or mad. Lipsedge points out that religious means were an effective way for women to gain an audience in cultures of female disempowerment.
Littlewood & Lipsedge (1989)	UK	Case study of a female patient in a state of extreme religious enthusiasm.	The patient was excited and talking or babbling incoherently. The psychiatrist thought this was glossolalia, but the members of her Pentecostal church said it was not.
Littlewood & Lipsedge (1978, 1981a, 1981b)	UK	Patients admitted with diagnoses of psychosis: 3 studies of hospital admissions	Many Afro-Caribbeans' had a paranoid and religious flavour, resembling "bouffees delirantes" described in the French West Indies, in which the persecutory content is often linked to witchcraft.

Ndetei (1988)	UK	Phenomenology of psychiatric illness in a London hospital, and socio-cultural backgrounds of West Indian, African and Asian immigrants to the UK (and other groups), all psychiatric in-patients, total n=593.	Paranoid and religious phenomenology associated with African and West Indian groups for cultural reasons rather than their socio-environmental and racial status in Britain. Paranoia was directed to fellow-immigrants rather than to the host population. Suggested that (auditory) hallucinations and first rank symptoms of schizophrenia do not have the same diagnostic significance in every culture, and that paranoid and religious phenomenology may not have the same clinical significance (among Africans and Afro-Caribbeans).
Ndetei & Vadher (1984)	UK	593 psychiatric inpatients from 9 cultural groups. Examined patterns of delusions.	Cultural differences in persecutory, grandiose, religious, sexual and fantastic delusions, all of which are at relatively higher frequencies in West Indian and African groups.
Redlener & Scott (1979)	USA	Case study of 9-month-old black child admitted to hospital with meningitis and brain damage. Mother devout and grandmother an ardent minister of the Holiness Church	The mother was described by the hospital social worker as relating to the child in a loving but unrealistic manner, says the child is special to her, fasts and prays for his recovery, attributes the illness to "demonic forces" and wants to take the child home. In court hearings regarding custody, the mother was evaluated as "paranoid-schizophrenic", and allowed supervised visits only. The child was eventually institutionalized. The authors suggest this tragedy was the result of incompatibility between medical and religious ideology.

Ward (1982)	various	4 case histories of 25-38-year-old women from syncretic subcultures in traditional societies	Spirit possession is examined as a form of personal maladjustment and as a form of social protest. Suggested that pathological possession states are precipitated by difficulties like those in industrialized societies, but are coloured by traditional beliefs.
Ward & Beaubrun	UK	20 members of a West Indian Pentecostal group, 16 women and 4 men, with belief in malevolent spirit possession, tested with the EPI and the neurotic hysteria scale of the MMPI.	The 10 subjects who were defined as spirit-possessed scored significantly higher on neuroticism and hysteria than did the control group. Suggested that possession may be a culture-bound disorder.

Table 8: Use of religious therapeutic practices among black people outside the UK and USA

Study	Country	Source and type of information	Findings and conclusions
Csordas (1987)	Brazil	Case vignettes from interviews with a Brazilian psychiat -rist who is an elder of the candomble cult	Patients's recovery assisted by referral, where wished, to candomble practitioners and practices. Good cooperation between psychiatrists and religious specialists.
Erinosho (1977a)	Nigeria	Retrospective study, 208 treated schizophrenics and next of kin, from 2 different centres	A substantial number of patients from all educational levels had previously sought help from native healers or syncretic churches.
Griffith (1983)	Jamaica	Interviews with 39 patients, 15 staff, pastor and clinic director or a church -based healing ministry.	Clinic offered health care integrating religious and medical/psychological beliefs. Patients led in prayer before referral for medical treatment or psychological counselling.
Idowu (1992)	Nigeria	Description of the Oshun festival	Traditional healing of mind, and soul; involves bathing in the Oshun river. Fosters self-esteem and group ties.
Lefever (1996)	Cuba	Social-anthropological analysis of Santeria from the C16th	Santeria is a syncretism of African religions, Roman Catholicism and French Spiritism. It was not (merely) an attempt to conceal the worship of African gods, but a way of harnessing and appropriating the power of the masters.
Peltzer & Ebigbo (1989)	Africa	Edited collection of descriptions of a wide range of traditional forms of healing (mainly in Africa)	Considers psychosocial and psychotherapeutic aspects traditional forms of healing, mainly in Africa, and including those used in hospitals and among Christian groups.
Roach	Trinidad	Observational	Studied use of Obeah

(1992)		study	in the treatment of mental illnesses believed to be caused by evil spirits.
Umoren (1990)	Nigeria	Case study of explanation and treatment of mental illness among the Annang	Explanations are based on a strongly religious worldview. Possession and nonpossession mental disorders are identified. This case did not involve possession, and treatment included relaxation, suggestion, manipulation, chains and tranquillising medicine.