

# Mental health, religion and culture

Kate M. Loewenthal and Christopher Alan Lewis look at how mental well-being can be affected by religious practice and cultural context

Psychologists have shown scant interest in the effects of religion on mental health, and much of the earlier work on this topic was done in Western, predominantly Christian societies. This article looks at what we can conclude so far about the effects of culture on the relations between religion and mental health, and highlights some areas of research interest. These include important questions about the effects of religious beliefs and practices, such as scrupulous cleanliness or communication with spirits, on the diagnosis and prevalence of psychological disorders.

## question

What do we know about the relations between religious factors and mental health? And how are these relations affected by culture?

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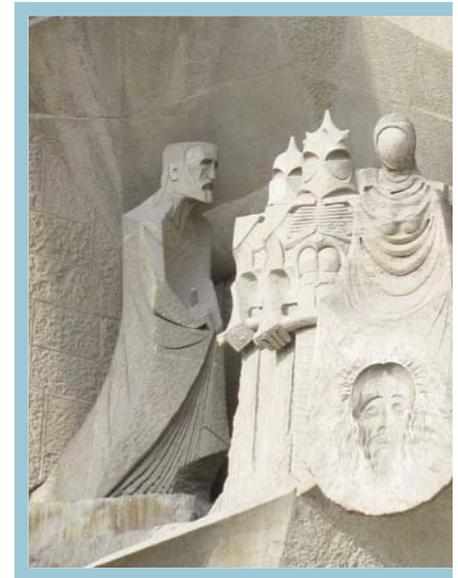
turn of the millennium, psychology was showing belated signs of trying to catch up in its study of religion and its effects, with the appearance of textbooks on the psychology of religion (e.g. Argyle & Beit-Hallahmi, 1997; Paloutzian, 1996), books on religion and mental health (e.g. Koenig et al., 2001; Loewenthal, 2007), seminal works such as Fraser Watts and Mark Williams's *The Psychology of Religious Knowing* (1988), and Kenneth Pargament's *The Psychology of Religion and Coping* (1997). In addition there are highly regarded journals, such as *Archive for the Psychology of Religion*, *International Journal for the Psychology of Religion*, *Journal for the Scientific Study of Religion*, *Journal of Religion and Health*, *Spirituality and Health International* and *Mental Health, Religion & Culture*.

The area has been dogged by problems of definition, and here we shall simply offer some basic definitions (Loewenthal,

Early 20th-century interest in religion and mental health was sparked by Freud's view of religion as intrinsically neurotic. Freud described religion and its rituals as a collective neurosis, which, he suggested, could save a person the effort of forming an individual neurosis. For example, in an early paper, Freud (1907/1924) spelt out the similarities between religious rituals and obsessional rituals. He argued that guilt is created when rituals are not carried out, and assuaged when they are, so a self-perpetuating 'ritualaholic' cycle is set up.

Freud's views prompted furious reaction from the religious establishment, leading in some circles to the dismissal of psychotherapy and psychotherapists as worthless atheistic frauds; but there were parallel counter-movements. Within psychodynamic theory and practice, and in the social scientific and psychiatric arenas, there were serious attempts to explore religiosity and spirituality and their mental health implications. For example Eaton and Weil (1953) wondered about the Hutterites, a religious group who inhabited a rural enclave in the USA, isolating themselves from modern society. Did the Hutterites' idyllic-seeming, pious rural life promote their mental health? Eaton and Weil's epidemiological study showed differences in patterns of psychiatric disorders from contemporary urban America.

Historically, issues of religion, mental health and culture have been taken more seriously by psychiatrists and sociologists than by psychologists. However, by the



Psychology is showing belated signs of trying to

2007). Religion involves agreed beliefs and behaviours about spiritual reality, God, morality, purpose, and the communication of these. Mental health may be defined as absence or lower levels of psychopathology and of distress, and also as the presence of positive affect. Culture may be defined as beliefs and customs shared by groups of people in a particular time and place.

Alongside problems of definition, the area of research is also hampered by methodological issues (Loewenthal, 2009). Cross-sectional, correlational designs involving psychometric measures (see Hill & Hood, 1999) have been very popular. However, there are important effects that can be masked by such designs – for example, it has been suggested that when people are under stress and developing mental health problems, they may draw on a range of religious coping methods, such as prayer, studying religious texts, and communal worship. As psychological

health improves, religious coping declines (Siddle et al., 2002). Correlational designs would suggest associations between religious practices and poor mental health, whereas longitudinal studies suggest a more complex set of effects, chiefly that religious coping may be helpful for well-being. Experimental designs are being introduced. For example, Birgegaard and Granqvist (2004) offer experimental evidence that religion and religious coping play different roles in the lives of those with secure and insecure childhood attachment histories. Although there is a tradition of using case material in this field of investigation, other qualitative material is lacking, and Belzen (2010) and others have argued strongly for more widespread use to enable understanding of the range and complexity of effects in different cultural settings.

Back to our opening question: What do we know about the relations between religious factors and mental health?

It would be impossible to attempt an exhaustive list. We highlight a few issues – the consolations of religion, religious stress, and anomalous experiences. We look at the influence of culture, using case studies to illustrate some of the key points.

### The consolations of religion

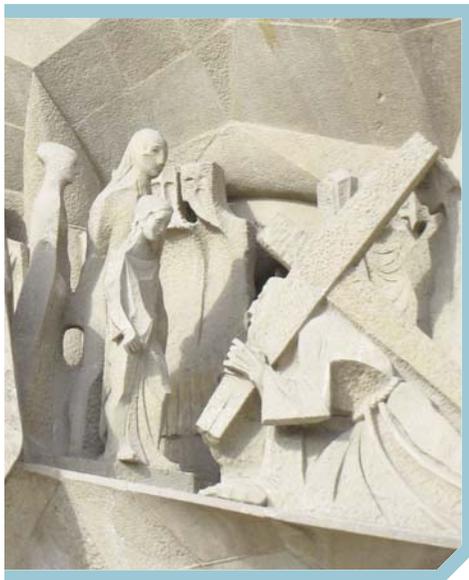
It is well documented that, usually, many religious beliefs and practices are associated with lower levels of depression and anxiety, and (where measured) higher levels of positive affect (Abdel-Khalek, 2007; Koenig et al., 2001; Loewenthal et al., 2000; Pargament, 1997), though the effects are not universally reported (e.g. Francis et al., 2003; Lewis & Cruise, 2006). Important beliefs seem to be those involved in religious faith and trust – ‘God is supporting me in this’, ‘This is ultimately for the best’. An important practice is prayer: Maltby et al. (1999) showed that when other factors were partialled out, prayer was an important predictor of well-being.

The general effect – that religion can be consoling and supportive – has been demonstrated in a range of cultures and religious groups including North American, European, Afro-American, Arab, South Asian, Christian, Jewish and Muslim. Much recent clinical literature has been occupied with discussions of how best to bring clinical practice in tune with religious and cultural needs (Cook et al., 2009; Pargament & Tarakeshwar, 2005; and see article by Adrian Coyle and Jenny Lochner on p.264).

### Religious stress

Religious factors, it has been suggested, are not always beneficial (Loewenthal, 2007; Pargament, 1997). For example, those who believe in a punishing God tend to have poorer mental health outcomes than those who believe in a benign, supportive God. However, some common suspicions about the harmful effects of religion have not always been borne out. For example it has been suggested that religion often fosters guilt, and this may serve to raise levels of anxiety, depression and obsessionality. Empirically, the effects are not so straightforward. True, generally there is an association between religiosity and measures of guilt and obsessionality, particularly in religious traditions that encourage scrupulous detailed observance, such as some forms of Roman Catholicism, Judaism and Islam. However, measures of guilt do not predict anxiety and depression, and measures of religiosity do not predict clinical obsessionality (obsessive-compulsive disorder, or OCD) (Lewis, 1998). Greenberg and Witztum (2001), in their studies of OCD among orthodox Jews, concluded that religion offers ways of expressing the disorder, but does not in itself foster the disorder:

Jonah is an orthodox Jew. His family kitchen has different utensils for cooking and serving milk and meat foods, and this is normal in orthodox-Jewish homes. Unlike other kosher



catch up in its study of religion and its effects

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kitchens, however, the cupboards are piled with stale loaves of bread, opened but disused bottles of tomato ketchup, 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 gets nervous 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, so Jonah doesn't want it used with milky food. Jonah's rabbi is frequently consulted. He has tactfully tried to convince Jonah that he is going to unnecessary lengths. Jonah's wife and children reached the end of their tether, and managed to

persuade Jonah to seek some professional advice (based on Greenberg & Witztum, 2001, pp.115–117).

This conclusion has been confirmed in other religious-cultural contexts. For instance, Tek and Ulug (2001) studied Turkish Muslim OCD sufferers, and found no relationship between religiosity and any of the clinical features of OCD, including the presence of religious obsessions. Like Greenberg and Witztum and other authors, they conclude that religion is not a determinant of OCD, simply an arena in which OCD is expressed.

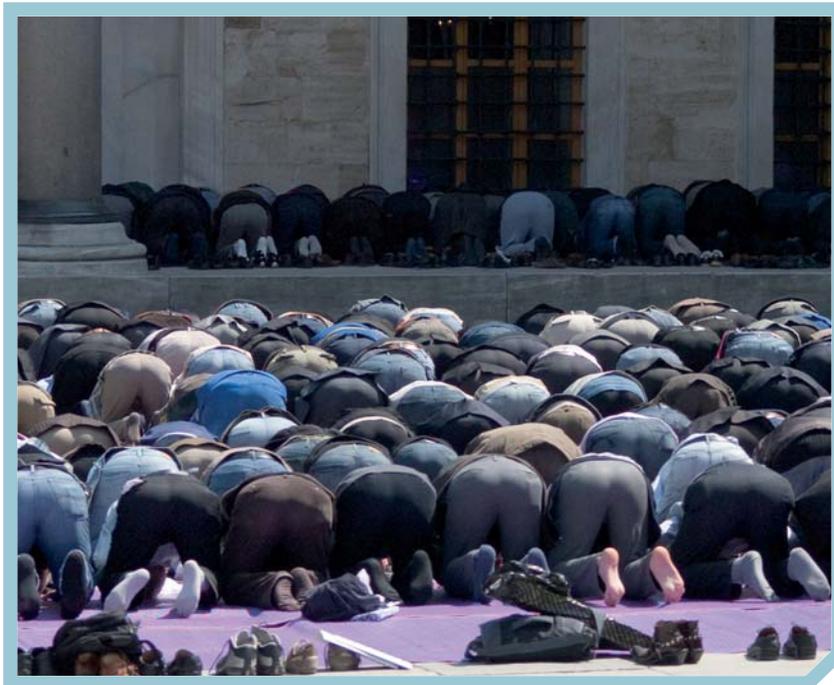
It is perhaps surprising that religious

guilt may not play a causal role in mental health problems. Equally surprising is the finding that some aspects of religious practice that appear unequivocally benign, may have harmful effects in some circumstances. For instance, although meditation has been claimed to have, and shown to have, calming affects, and mindfulness (said to be based on meditative techniques) is an increasingly popular technique in cognitive therapy, there have been some puzzling suggestions that meditation may precipitate manic episodes in those who are prone to bipolar disorder (e.g. Yorston, 2001).

Ms X was in her 20s. She had no previous psychiatric history, but had experienced two periods of low mood in the past. These resolved without professional intervention. She went on a weekend yoga course encouraging psychological release. After this she became very restless, sleepless and talkative and frequently telephoned the yoga instructor offering her undying love. She was voluntarily admitted to psychiatric hospital, but then was compulsorily detained after she began shouting, embracing some staff and hitting others, and declaring that she had a mission to save the world by offering undying, unconditional love to everyone. This manic state responded to medication, but it was noted that manic episodes seemed to be preceded by days spent in Zen meditative retreat. Eventually she refused treatment and entered the Buddhist retreat. (from Yorston, 2001, pp.210–11)

### Anomalous experiences

What about voices, visions and demons? Do religions encourage such experiences and beliefs, and thereby foster psychotic episodes? The short answers are, yes to the first part of the question – many religions do indeed encourage or support voices, visions and beliefs in malign spiritual forces, but no to the second



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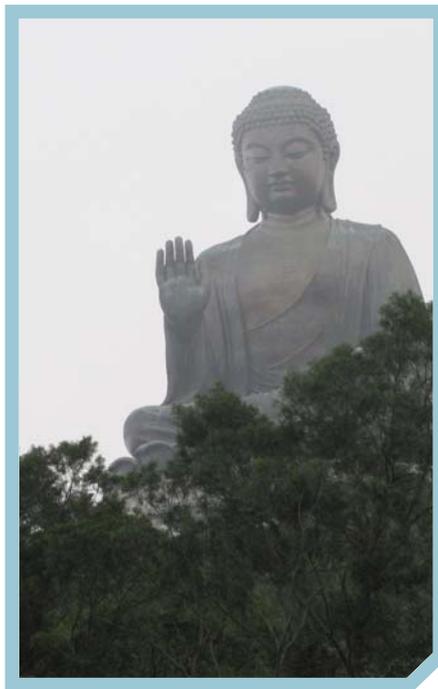
Yorston, G. (2001). Mania precipitated by meditation: A case report and literature review. *Mental Health, Religion & Culture*, 4, 209–214.

question – religion is unlikely to foster psychotic illness. However, voices, visions and other exotic religious practices, beliefs and experiences may lead to the mistaken belief that a person is suffering from psychosis (i.e. misdiagnosis).

To amplify these points, a number of studies have shown generally zero or negative correlations between measures of religiosity, and measures of schizotypy (Joseph & Diduca, 2001), and also 'P' (the measure of psychoticism on the Eysenck Personality Questionnaire, see Eysenck, 1998; Lewis, 1999). Studies by Peters et al. (1999) and Davies et al. (2001) have examined delusions and the experience of voices among groups of individuals diagnosed as psychotic, non-psychotic individuals who are religiously active, and non-psychotic individuals who are not religiously active. Generally, the religiously active are more likely to experience visions, voices and 'delusions' than others, though the religiously inactive may also have such experiences. The crucial features that distinguish psychotic experiences of visions, voices and the like from non-psychotic religious experiences are that psychotic experiences are generally more unpleasant, unwanted and uncontrollable.

Turning to the misdiagnosis issue, there is considerable case history material to suggest that religious beliefs and practices, especially where these are culturally alien, may be seen as psychiatric symptoms. Here is an example from the early 20th century (in Loewenthal, 2007, p.37):

A young Afro-American woman worked in domestic service in the United States early in the last century. She developed a stomach disorder and could not afford an orthodox medical practitioner, so she went to a West Indian herbalist. Not only was the herbal treatment unsuccessful, the herbalist was reported to have made unwelcome sexual advances. The young woman's behaviour became disturbed and she was sent to her sister's home, but did not calm down. ... She now became very sure that the herb doctor had put a spell on her and she read her Bible constantly to exorcise it. She was admitted to a psychiatric hospital, where she refused to eat or talk. She thought the food was unholy and also the people about her unholy. She read



her Bible, and prayed all day long, and was said to be suffering from dementia praecox (schizophrenia).

We cannot leave our discussion of mental health, religion and culture without at least a brief look at spirit possession and spells. Are malign spiritual forces outmoded and primitive explanations for mental illness? They are widespread in many cultures (including Western cultures, see Loewenthal, 2007). Many transcultural psychiatrists and psychologists find that it is important to incorporate patients' beliefs about the causes of their disorders into treatment plans (see article by Adrian Coyle and Jenny Lochner on p.264). Regardless of any personal scepticism, a respectful, postmodern acknowledgement of the validity of alternative explanatory frameworks may be essential for therapeutic progress (Cook et al., 2009). Consider this example:

Saleh was born in Egypt, lived and studied in London, a lifelong orthodox Muslim, praying regularly. Saleh had a bad relationship with his cousin, Mohammed, believing that he was jealous of him. Mohammed practiced magic, even though this was forbidden in Islam. One day following an argument, Mohammed cursed Saleh, telling him he would die. Saleh stopped eating and drinking, became very withdrawn and stayed in his room. Following medical advice, he was compulsorily admitted to

hospital, where his consultant instituted drip feeding, and diagnosed depression, saying that Saleh's belief about being cursed was a delusion. Saleh continued to believe he had been cursed, and felt very guilty about having upset his cousin. He failed to improve and there was considerable concern about his life being in danger. His parents called a 'counter-magician' who was able to remove the curse from Saleh. After this Saleh began to eat and drink and his mood improved rapidly. He was discharged two days later (Dein, 2003, pp.198-199).

## Conclusion

There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder), voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health.



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