

## Section on Personal Identity, Experience and Meaning in Health

# Culture, religion and health care

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## Introduction

The field of cultural psychiatry explores the link between clinical descriptions of mental distress, biological and physiological manifestations of distress, and social and environmental factors. *Cultural psychiatry has expanded its field of interest from clinical psychiatry and treatment of the individual patient to public health and global health and well-being. Cultural psychiatry as a discipline has its origins in medical anthropology and is particularly focussed on exploring the cultural influences on the expression of symptoms, interpretations and explanatory models for symptoms, coping style and responses from family, relationships with carers, mental health professionals and traditional healers.* Each of these contributes to thinking about an overall diagnosis, and should take account of spiritual and religious.

## Culture and mental health

Helman has defined culture as “a set of guidelines which individuals inherit as members of a particular society which tells them how to view the world, experience it emotionally and how to behave in relation to other people, supernatural forces or Gods and to the environment. Culture is transmitted by symbols, language, art and ritual” [1]. Culture, thus defines what is ‘normal’ and ‘abnormal’ and influences the presentation and distribution of mental illness. Culture also influences the way mental illness is recognised and treated by members of the society and sanctions particular healers in a society. Nonetheless, there are limitations to cultural analyses, for example, the more biological the origin of a particular disorder the more likely it is to be invariant in its presentation, albeit idioms of distress may still vary across cultural groups. It is, therefore, ‘common mental disorders’ for which there are substantial cultural variations in explanatory models and treatment expectations. Yet, culture is not a static entity. Cultural identity and beliefs vary over time in response to the cultural beliefs found in society, and for immigrants, the cultural beliefs that are dominant.

Acculturation has been defined by as the phenomenon which results when groups or individuals have different cultures and come into first hand contact with subsequent change in the original cultural patterns of either or both groups [2]. In our work with young people in East London we studied the relationship between cultural identity and mental health of adolescents and discovered that this relationship varies by cultural group and also some risk factors are better for some groups than others [3, 4]. Furthermore, the DSM-IV cultural formulation argues for assessing cultural identity as part of the overall assessment of a patient alongside the cultural explanation of the individual’s illness, cultural factors relating to the psychosocial environment and functioning, cultural elements of the relationship between the individual and the clinician and an overall culturally appropriate assessment and diagnoses and treatment plan. In the schema generated by Tseng, in the Handbook of cultural psychiatry [5], the essential elements of a cultural assessment include sensitivity, knowledge, empathy, therapeutic relations and interactions, and treatment guidance. Cultural competence can be operative both at an individual level and also at an organisational level and the values of the organisation and the individual link these domains.

Although understanding religion and spirituality and health is not embraced by all health professionals as being central to the delivery of mental healthcare, cultural psychiatrists have, for a long time, investigated, explored and harnessed the knowledge of religious communities and leaders in understanding mental distress and improving treatment. They have done this because the exploration of variations in beliefs and expressions of distress and treatments is fundamental to the task of a cultural psychiatrist, especially where patient and professional differ in their cultural or religious orientation.

## **Religion and mental health**

McCullough and Larson point out the general positive association between religiosity and a number of physical and mental health outcomes [6]. Some forms of religious coping are associated with better mental health outcomes: a belief in a just benevolent God, experience of a God as a supportive partner in coping, involvement in rituals and a search of support through religion [7]. Pargamant and Kendler both found that a poor quality of relationship with God and religious conflicts are associated with poor and health outcomes and a higher mortality [8, 9]. Some religious behaviours and beliefs are promoted as having protective influences that moderate the impact of adverse inter-personal life events and social adversity, and the use of substances [10, 11].

## **Spirituality and religion**

The Cambridge dictionary defines spirituality as the quality of being concerned with deep often religious feelings and beliefs rather than physical aspects of life [12]. Culliford suggests that spiritual aspects of coping with depression include doubt and questioning everything, exhaustion, demoralisation and feeling ground down [13]. Spirituality, therefore, is a common attribute of human existence and one that perhaps is not recognised or embraced by many people. Spirituality may be understood as different from organised religion and religious practice, yet all of these may be used by people to cope with distress, either through changes states of self, and or through ritual and relationships.

It is in this context that we undertook a large public health study of six ethnic groups in the UK in the EMPIRIC Study. A qualitative component included 116 people. The subjects described how they coped with mental distress. Their accounts were recorded, transcribed and subjected to framework analysis [14]. The sample included 49 men and 67 women of Black Caribbean, Black African, White British, Irish, Indian, Bangladeshi and of Pakistani origin. The sampling was unclustered, including 25–50 years old. The majority of people were of Muslim origin (40) or Christian (25) with smaller numbers of Sikh, Hindu, Buddhist and Rastafarian people. The detailed methodology and analysis has already been reported [14]. The findings suggest that religious coping was used a great deal by Black Caribbean Christians and Bangladeshi Muslims and that there was quite a distinction in the relationship with God expressed in their conversation. This ranged from a deferential relationship-placing trust in God-being able to endure anything sent from God, to talking to God in a more flexible and instrumental way at times of suffering. This included using prayer, religious radio and amulets. There was also evidence that emotional turmoil was sometimes seen as a sign of not being sufficiently religious and amulets prayer and religious radio could also be used. Religious identities and cultural identities were not separate for all groups, specifically the Muslim group. Or perhaps Muslims in our sample were the most religious and similar findings would be found among very religious people from other faiths. Religious and spiritual rituals were often used to cope with mental distress, even amongst the non-religious, paradoxically.

The findings argue that identity and explanatory models should be assessed in mental health care and expectations of treatment and attitudes of treatment and medical interventions should be considered alongside the individual's religious orientations and existing coping strategies which may have their origins in spiritual beliefs of practices. These may not be expressed in formally organised religion.

In order to further understand the relationship between religion and mental health and incorporate this in routine practice clinicians will inevitably encounter the need to consider technical modifications, theoretical modifications and philosophical reorientation of their work [5, 15].

This brief paper sets out some of the reasons why religion and spirituality are important aspects of mental health-care but the paper did not deal with racism, prejudice or group hatred, religiously, racially or culturally specific services. It did not deal with inequalities of access to service and effective treatment. Nor does it deal with developing effective intervention trials in diverse cultural and religious groups. Nonetheless, the central thesis is that cultural

assessment be part of a comprehensive individual personal assessment and treatment plan; assessment should include aspects of spirituality and religious orientation and identity. In some instances, this may require therapists with a particular religious persuasion [15, 16] but otherwise it requires culturally and religiously informed clinicians. Further research is needed on the links between culture and identity and how identity links with faith and spirituality and leads to altered states of self which mediate, moderate or determine varying levels of mental distress. The influence of religious and spiritual beliefs on coping strategies and on attitudes to conventional treatments also warrants further investigation. Pluralistic help seeking is not uncommon [17]. A person-centered psychiatry and person-centered medicine, therefore, does need to accommodate pluralistic notions of mental healthcare, including the influence of religious practice and belief and spirituality in mental health care [18].

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