

# Cross-Cultural Considerations for Differentiating between Religiosity and Psychosis

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# Cross-Cultural Considerations for Differentiating between Religiosity and Psychosis

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## Abstract

This paper addresses the question of how to approach religiosity and psychosis within a clinical context. A clinician who is tasked with the differential diagnosis of a client who is apparently either experiencing normative religious phenomenon or psychotic symptoms faces a difficult situation—as clinicians are generally ill-prepared to address topics related to spirituality. It is important for a clinician to be culturally informed and culturally sensitive, and yet religiously-themed hallucinations and delusions are commonly observed among individuals experiencing psychosis. Recommendations are made to help inform culturally appropriate diagnosis and practice.

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How do clinicians differentiate between anomalous religious experience and hallucinations? How do clinicians differentiate between religious beliefs and delusions? How does religiosity relate to psychosis? This paper will seek to illuminate the intersection between religiosity and psychosis. Specific attention will be paid to clinical considerations regarding differential diagnosis and culturally-sensitive care.

## Religion and Mental Health

Religious background is a socio-cultural variable that is an important part of a person's identity. Multicultural guidelines have been given for working with diverse populations (American Psychological Association, 2002), and yet some friction still exists between psychology and religion (Cummings & Cummings,

2009; Ng, 2007). In considering the impact of religion and spirituality upon an individual it is important to be mindful of how complex the impact of religion and spirituality can be upon a person's values, perceptions, and experiences. Koltko stated that "although we speak of a client's 'religious background,' for many clients religious issues are in the foreground of their lives" (1990, p. 132). For some, religiosity is more than a preference or affiliation, it is an integral part of their identity. It guides how they view themselves and the world around them and impacts the decisions they make. For some, their religious affiliation and spiritual practice is who they are.

For the purposes of this paper it will be important to standardize the terms spirituality and religion. Spirituality and religion are thought to be two distinct yet

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overlapping concepts. Spirituality refers to an individual's search for and understanding of meaning in life, as well as a connectedness to others, deity, and nature. Religion is thought to refer to a faith-based community that holds a similar set of spiritual beliefs, practices, and values (Shah et al., 2011).

Further it has been suggested that a person may be high or low in one or both their spirituality and religiosity, meaning that a person may be high in spirituality and low in religiosity, low in spirituality and high in religiosity, high in both, or low in both.

### *Historical Context*

In considering the intersection of religiosity and pathology, it is important to understand the historical relationship between religion and psychology. Freud described religion as being a "mass-delusion" and the "universal obsessional neurosis of humanity" (as cited in Pierre, 2001, p. 163). Similarly Ellis equated religion with irrationality and pathology (as cited in Pierre, 2001). It has been stated that in mental health, religion has mostly been viewed in terms of pathology (May, 1997). This pathologizing of religion has led to strained relations from both psychology and religion (Cummings & Cummings, 2009).

Many clinicians are uncomfortable addressing issues of religion and spirituality (Huguelet et al., 2011). This may be due to markedly lower rates of theism found in psychologists and psychiatrists than those found in the general population (Pierre, 2001). It has been suggested that American psychology's views have been influenced by "militant atheism" (Cummings & Cummings, 2009, p. 315). It has yet to be established that psychology in general devalues religion, yet there is a perception in some of the literature that religion is viewed unfavorably and diminutively by psychologists (Cummings & Cummings, 2009). These possible biases and perceptions of biases serve as barriers to communication and culturally sensitive patient care.

### *Clinician Biases*

Ng suggested that "Clinicians have inherent biases where religious interpretations are required" (2007, p. 65). As was discussed earlier, a number of prominent figures in the history of mental health possessed and expressed a number of biased views regarding religion

(Pierre, 2001). It is the perceptions of some psychologists that these biases persist and serve as a barrier to proper client care (Cummings & Cummings, 2009).

The interplay between religion and science can be difficult, as religion tends to be intuitive, abstract, intangible, and conceptual, while science strives to be reductionistic and empirical (Ng, 2007). It has been suggested that friction occurs when psychologists strive to reductionistically view religion as a purely psychological phenomenon (Cummings & Cummings, 2009).

Examples of this friction include academic settings, where openly religious faculty and students are generally a small minority who face open biases in curricula and interactions with nonreligious staff (Cummings & Cummings, 2009). Further it has been found that patients seeking therapy in faith-based counseling centers commonly complain about previously not being able to fully relate to or benefit from therapy in non-faith-based counseling centers. Those clients explained that they had "discerned" (p. 324) disinterest on the part of their clinician. It was unclear if this disinterest was due to a general discomfort regarding spiritual themes, unease associated with a lack of confidence on how to discuss spirituality, or outright bias against religion. However, it is clear that clients may be both perceiving and responding to the message that therapy is not an appropriate setting to discuss one's spirituality. Also, it appears that these perceived biases served as a barrier to effective client care.

The *Journal of Theoretical and Philosophical Psychology* recently featured a special issue entitled "Is there a pervasive implicit bias against theism in psychology?" In that edition Slife and Reber (2009) contend that there is. A number of researchers responded to Slife and Reber's claims of atheistic bias. Richardson (2009) criticized their article and agreed with the conclusion that pervasive anti-theistic biases exist in psychology; however, Alcock (2009) refuted these claims of implicit biases and stated the argument was "Christian propaganda" (p.80). There remains some disagreement about the existence or pervasiveness of anti-theistic biases in the field of psychology. Whether these biases actually exist, they certainly are perceived, and as discussed above even the perception of bias can be a barrier to communication and progress.

## Religiosity and Psychosis

It has been suggested that when considering the cultural impact of religion, a clinician should also keep in mind the variability associated with individual and subgroup differences (May, 1997). Some researchers have examined the frequency and severity of religious delusion in Christian patients with psychosis (Getz, Fleck, & Strakowski, 2001). They found that Protestants experienced a greater frequency of religious delusions than their Catholic and nondenominational counterparts. However, it was found that religious affiliation did not predict the severity of the religious delusions. It was found that patients who were most active in their faith experienced the most severe religiously-themed delusions (Getz et al., 2001).

Also, a patient's religious and spiritual practice may influence how they conceptualize their mental illness. Research has found that patients with psychotic diagnoses and who were involved in religious communities commonly viewed spiritual-themes as partially responsible for their symptoms that professionals would call mental illness (Huguelet, Mohr, Gillieron, Brandt, & Borrás, 2010). A patient's conceptualization of their presenting problems is an important treatment consideration for the clinician to understand.

Another important consideration is the effect of religiously-themed delusions upon an individual's involvement in religious communities. One study found that individuals with religious delusions received less social support from religious communities when compared to religious individuals with nonreligious delusions (Mohr et al., 2010a). It was hypothesized that, due to the cohesive nature of religious communities, that members of these communities may have difficulty tolerating deviations in religious teachings and practices. For one obvious example, members of an evangelical Christian church may have difficulty relating to an individual who holds the delusional belief that they are Jesus Christ.

### *Religious Coping*

A person's coping with mental illness is influenced by their religiosity and spirituality (Shah et al., 2011). It has been observed that religious beliefs and practice have the potential for a number of positive outcomes including a positive optimistic worldview, a sense of

meaning in life, and a supportive community (Mohr et al., 2010b; Shah et al., 2011). Further, it has been found that patients with schizophrenia tend to rely less on active problems solving and more on passive avoidant strategies to cope with their mental illness. Yet patients with schizophrenia who were rated as being high on spirituality and religiosity more frequently used methods associated with focusing on personal growth and finding meaning to cope (Shah et al., 2011).

Another important consideration is the influence of religious and spiritual practice upon substance use in patients diagnosed with schizophrenia. Co-occurring substance abuse and substance dependence among patients with schizophrenia is a major treatment issue (Huguelet, Borrás, Gillieron, Brandt, & Mohr, 2009). Research has found that involvement in religious practice and community is negatively correlated with substance use in individuals with schizophrenia; meaning that people who met diagnostic criteria for schizophrenia and were involved in a religious community were less likely to be misusing substances than their nonreligious counterparts. Also, this research suggested that religious involvement with individuals with schizophrenia might serve as a protective factor for initial substance misuse and relapse into chemical dependency (Huguelet et al., 2009).

There are mixed findings as to whether religiously-themed delusions predict a poorer outcome than non-religiously-themed delusions (Mohr et al., 2010a). Individuals with religiously-themed delusions may not experience poorer outcomes than individuals with non-religiously-themed delusions; however, there is some indication that individuals with religiously-themed delusions may form poorer therapeutic alliances (Mohr et al., 2010a). It is thought that this may be due to both clinician anti-theistic biases and the fervor associated with religious delusions.

### *Differential Diagnosis*

It will be important to consider the diagnostic instructions given to clinicians to assess whether anomalous experiences constitute psychosis.

Isolated experiences of hearing one's name called or experiences that lack the quality of an external percept (e.g., a humming in one's head) should also not be considered as symptomatic of schizophrenia or

any other psychotic disorder. Hallucinations may be a normal part of religious experience in certain cultural contexts. Certain types of auditory hallucinations (i.e., two or more voices conversing with one another or voices maintaining a running commentary on the person's thoughts or behavior) have been considered to be particularly characteristic of schizophrenia. If these types of hallucinations are present, then only this single symptom is needed to satisfy Criterion A. (American Psychiatric Association, 2000, p. 298)

The Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-IV-TR; American Psychiatric Association, 2000) states that hallucinations may be a normal part of religious experience, and yet there is no means given to determine what constitutes a "normal part of religious experience." Generally clinicians are not trained theologians, and they are ill equipped to assess the normalcy of an individual's religious or spiritual experience.

Extant literature provided little guidance on how to differentiate between anomalous experiences, religious experiences, and hallucinations. Prince (1992) pointed out that "highly similar mental and behavioral states may be designated psychiatric disorder in some cultural settings and religious experiences in others" (as cited in Lukeoff, 2005, p. 235).

Moreira-Almeida and Cardeña (2011) found that anomalous and psychotic-like experiences are common in the general population. Moreira-Almeida and Cardeña suggest that around 90% of these cases are not associated with psychotic disorders. They pointed out that spiritual experiences often include non-pathological dissociative or psychotic experiences.

Differential diagnosis between religious experience and psychotic experience is difficult as there are no clear guidelines to distinguish between "normative" and "pathological" religious beliefs (Mohr et al., 2010a; Pierre, 2001).

The DSM-IV TR defines delusions as "erroneous beliefs that usually involve a misinterpretation of perceptions or experiences...The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear contradictory evi-

dence regarding its veracity" (p. 298).

A delusion has been described as a strongly held false belief. Yet determining if a religious belief is delusional based upon the fallacy of the belief is difficult as there is no means to objectively observe or test the veracity of the belief. With this in mind, Pierre (2001) offered clinical considerations for differential diagnosis. He stated that determining whether a belief was delusional based upon content was not a useful distinction. He stated that instead it was more relevant to look at the person's relationship with the belief, asserting that delusional patients told their beliefs in a qualitatively different manner than non-delusional patients. Pierre suggested that clinicians focus on the strength of the conviction, preoccupation, and identification associated with the belief.

The counsel to focus on the relationship of the belief rather than the content is consistent with the writings of Mohr et al. (2010a) who discussed the utility of examining the non-content aspects of a delusion.

Lukoff (2005) suggested that DSM-IV-TR V-code of Religious or Spiritual Problem (American Psychiatric Association, 2000) could be an appropriate diagnostic label for anomalous experiences with religious themes. "Spiritual emergencies warrant the DSM-IV diagnosis of religious or spiritual problem, even when psychotic symptoms may be present, including hallucinations and delusions" (p. 239).

## Recommendations

Based upon the information discussed above the following three recommendations are made to enhance the treatment of individuals with schizophrenia or other delusional mental illness:

### 1. *Spiritual Assessment*

It is essential that clinicians inquire about patients' religious and spiritual practices. Mohr et al. (2010a) called for a systematic assessment of spirituality in all patients. Huguelet et al. (2011) presented a method of assessing spirituality and religiosity in outpatients with schizophrenia. They asserted that their method was "well tolerated" (p. 81). The topics covered in their spiritual assessment included: religious and spiritual history, effect of the illness on spirituality or religious-

ness, current spiritual or religious beliefs and practices, subjective importance of religion in general, subjective importance of religion in coping with the illness, and synergy of religion with psychiatric care. Additionally, the Joint Commission on Accreditation of Healthcare Organizations mandates that sites provide a spiritual assessment (The Joint Commission, 2008) and provides a sample list of questions to ask including: “Does the patient use prayer in their life?” and “How does your faith help the patient cope with illness?”

## 2. Differentiating between Pathology and Faith

The demarcation between “normative” religious belief and religiously-themed delusions is not clear. It has been suggested that the demarcation between “normative” religious beliefs and psychotic experiences can be ambiguous, and consequently it has been recommended to view this distinction as existing on a continuum (Ng, 2007).

The recommendations of Pierre (2001) and Mohr et al. (2010a) are echoed. It is recommended that clinicians who desire to differentiate between religious experience and pathology focus not on the unverifiable content of the belief, but rather on the conviction, preoccupation, and identification with the belief.

Furthermore, it is recommended that clinicians strive to have open minds in regards to the religious and spiritual beliefs of the client. Included are some wise words on the topic from Koltko (1990):

The wise therapist does not attempt to excise or change normative religious beliefs and values (i.e., the values and beliefs adopted by a community of believers over several generations). Those beliefs and values have been extant for much longer than the therapist’s approach to treatment...The wise therapist uses information about a specific religion as a backdrop. It is most important to know what a client’s religion means to the client, as well as what that religion ‘officially’ states...Finally, the wise therapist skillfully uses the power inherent in a client’s beliefs to enhance the client’s functioning. Religion is orthogonal to pathology. (p. 139)

The advice given by Koltko not only applies to working with persons with schizophrenia, but rather this advice could be pertinent working within a multitude of set-

tings with varying populations.

## 3. Incorporating Spiritual Care Providers into Treatment

It has been pointed out that mental health clinicians are generally ill equipped to assess spiritual and religious beliefs, and yet are expected to assess for the presence of psychopathology (Ng, 2007). Means of improving the current situation may include systematic changes. Mohr et al. (2010a) suggested that mental health providers seek the advice and needs of the clergy. Some treatment settings may want to consider the possible benefits and drawbacks of including a chaplain or religiously oriented individual on interdisciplinary treatment teams.

Individuals with religiously-themed delusions may be at risk of being alienated from religious communities (Mohr et al., 2010a). It is supposed that if religious leaders were to be more involved with treatment that they would be able to encourage outreach and fellowship with these vulnerable individuals.

## Summary and Conclusions

In summary, psychology and psychiatry have a history of devaluing religion. These biases may serve as a barrier to delivering culturally sensitive care to religiously and spiritually oriented patients. Anomalous experiences may be common to the human experience and may not be indicative of psychosis. One area where the interaction between mental health and religion can be especially difficult is the intersection of religiosity and psychosis. Little instruction is given in the DSM-IV-TR to determine if an individual’s religious belief is normative or delusional. Making this determination based upon the content of the belief may not be useful, and it is instead recommended that these decisions be based upon the person’s relationship with the belief. It is important to investigate the conviction, preoccupation, and identification with the belief.

## References

- Alcock, J. E. (2009). Prejudice or propaganda. *Journal of Theoretical and Philosophical Psychology*, 29(2), 80-84. <http://dx.doi.org/10.1037/a0016968>
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- American Psychological Association. (2002). Guidelines on multicultural education, training, research, practice, and organization change for psychologists. Washington, DC: Author.
- Cummings, J. L., & Cummings, N. A. (2009). The proliferation of faith-based counseling: Booming while psychotherapy declines. In N. C. Cummings, W. O'Donohue, & J. Cummings (Eds.), *Psychology's war of religion* (p.313-333). Phoenix, AZ: Zeig, Tucker & Theisen, Inc.
- Getz, G. E., Fleck, D. E., & Strakowski, S. M. (2001). Frequency and severity of religious delusions in Christian patients with psychosis. *Psychiatry Research*, 103(1), 87-91. [http://dx.doi.org/10.1016/S0165-1781\(01\)00262-1](http://dx.doi.org/10.1016/S0165-1781(01)00262-1)
- Huguelet, P., Borrás, L., Gilliéron, C., Brandt, P.-Y., Mohr, S. (2009). Influence of spirituality and religiousness on substance misuse in patients with schizophrenia or schizo-affective disorder. *Substance Use & Misuse*, 44, 502-513. <http://dx.doi.org/10.1080/10826080802344872>
- Huguelet, P., Mohr, S., Betrisey, C., Borrás, L., Gilliéron, C., Marie, A. M.,...Brandt, P.-Y. (2011). A randomized trial of spiritual assessment of outpatients with schizophrenia: Patients' and clinicians' experience. *Psychiatric Services*, 62(1), 79-86. <http://dx.doi.org/10.1176/appi.ps.62.1.79>
- Huguelet, P., Mohr, S., Gilliéron, C., Brandt, P.-Y., & Borrás, L. (2010). Religious explanatory models in patients with psychosis: A three-year follow-up study. *Psychopathology*, 43, 230-239. <http://dx.doi.org/10.1159/000313521>
- Koltko, M. E. (1990). How religious beliefs affect psychotherapy: The example of Mormonism. *Psychotherapy*, 27(1), 132-141. <http://dx.doi.org/10.1037/0033-3204.27.1.132>
- Lukeoff, D. (2005). Spiritual and transpersonal approaches to psychotic disorders. In S. G. Mijares, & G. S. Khalsa (Eds.), *The psychospiritual clinician's handbook: Alternative methods for understanding and treating mental disorders* (233-257). Binghamton, NY: Haworth Reference Press.
- May, C. A. (1997) Psychopathology and religion in the era of 'enlightened science' - a case report. *European Journal of Psychiatry*, 11(1), 14-20.
- Moreira-Almeida, A., & Cardena, E., (2011). Differential diagnosis between non-pathological psychotic and spiritual experiences and mental disorders: A contribution from Latin America studies to the ICD-11. *Revista Brasileira de Psiquiatria*, 33(1), 529-536.
- Mohr, S., Borrás, L., Betrisey, C., Brandt, P.-Y., Gilliéron, C., & Huguelet, P. (2010a). Delusions with religious content in patient psychosis: How they interact with spiritual coping. *Psychiatry*, 73(2), 158-172. <http://dx.doi.org/10.1521/psyc.2010.73.2.158>
- Mohr, S., Borrás, L., Rieben, I., Betrisey, C., Gilliéron, C., Brandt, P.-Y., Perroud, N., & Huguelet, P. (2010b). Evolution of spirituality and religiousness in chronic schizophrenia or schizo-affective disorders: A 3-years follow-up study. *Social Psychiatric Epidemiology*, 45, 1095-1103. <http://dx.doi.org/10.1007/s00127-009-0151-0>
- Ng, F. (2007). The interface between religion and psychosis. *Australasian Psychiatry*, 15(1), 62-66. <http://dx.doi.org/10.1080/10398560601083118>
- Pierre, J. M. (2001). Faith or delusion? At the crossroads of religion and psychosis. *Journal of Psychiatric Practice*, 7, 163-172. <http://dx.doi.org/10.1097/00131746-200105000-00004>
- Richardson, F. C. (2009) Biases against theism in psychology? *Journal of Theoretical and Philosophical Psychology*, 29(2), 122-127. <http://dx.doi.org/10.1037/a0017689>
- Shah, R., Kulhara, P., Grover, S., Kumar, S., Malhotra, R., & Tyagi, S. (2011). Relationship between spirituality/religiousness and coping in patients with residual schizophrenia. *Quality of Life Research*, 20, 1053-1060. <http://dx.doi.org/10.1007/s11136-010-9839-6>
- Slife, B. D., Reber, J. S. (2009). Is there a pervasive implicit bias against theism in psychology? *Journal of Theoretical and Philosophical Psychology*, 29(2), 63-79. <http://dx.doi.org/10.1037/a0016985>
- The Joint Commission (2008). Spiritual Assessment. Retrieved from [http://www.jointcommission.org/mobile/standards\\_information/jcfaqdetails.aspx?StandardsFAQId=290&StandardsFAQChapterId=29](http://www.jointcommission.org/mobile/standards_information/jcfaqdetails.aspx?StandardsFAQId=290&StandardsFAQChapterId=29)

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