# RELIGION/SPIRITUALITY IN AFRICAN-AMERICAN CULTURE: AN ESSENTIAL ASPECT OF PSYCHIATRIC CARE

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There is an astonishing diversity of religious beliefs and practices in the history of African Americans that influences the presentation, diagnosis, and management of both physical and mental disorders. The majority of African Americans, however, are evangelical Christians with religious experiences originating in the regions of ancient Africa (Cush, Punt, and to a great extent, Egypt), as well as black adaptation of Hebraic, Jewish, Christian, and Islamic beliefs and rituals. Consequently, more than 60 of the nation's 125 medical schools offer classes in spirituality and health. Although there is a lack of empirical evidence that religion improves health outcomes, physicians should understand patients as a biopsychosocial-spiritual whole. Asking about religion/spirituality during a health assessment can help the physician determine whether religious/spiritual factors will influence the patient's medical decisions and compliance. Two psychiatric case histories of African Americans are presented in which religion/spirituality significantly influenced treatment decisions and results. Neither of these patients suffered major debilitating medical comorbidity. (*J Natl Med Assoc.* 2002;94:371–375.)

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Health professionals are encouraged to become competent in interpreting the role of culture and religion in the manifestation and treatment of mental disorders in African Americans. The presence of hallucinations, states of demonic possessions, speaking in tongues, and "falling out" episodes as described by Atwood Gains, an African-American anthropologist, are examples of behaviors noted in some African Americans that can be mistaken for psychopathology.[1] Religion/spirituality is an integral part of all sociocultural systems and, as such, often motivates human beings to believe supernatural forces have a reality of their own. Fundamentalism, which is an aspect of most African Americans' world view, adhere to an inerrant scriptural hermeneutic, a separatist attitude, and loyalty to an authority-centered group.[2]

Historians note that African-American religion originated in the regions of ancient Africa, e.g., Cush, Punt, and Egypt, and was subsequently influenced by the institution of slavery and colonialism. Therefore, it is argued that African-American religion, to a large extent, is a re-worked Christianity that has its own character and style.[3,4]

Because of the distinct cultural characteris-

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tics, religious beliefs, values, and practices of African Americans, clinicians should be alert when African-American patients present with atypical behaviors that are inconsistent with symptoms found in the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM-IV).[5] Regrettably, when professionals are confronted with complex religious/spiritual clinical situations, too often the patient is blamed for the confusion. It is also true that some clinicians resist accepting the fact that their personal characteristics, values, attitudes, and religious/spiritual biases can affect their communication with patients.[6,7] It can be especially frustrating when patients assert that a belief in divine intervention prevents them from accepting medications or they refuse blood transfusions. When there is an impasse or the inability to communicate with a patient because of religion issues, it is wise to seek consultation from religious/spiritual leaders, cultural brokers, or make treatment exceptions within ethical boundaries.[8,9] When patients prefer to discuss personal religious/spiritual matters with their physicians, much will depend on the interest and skill of the physicians.

## INCREASED AWARENESS OF SPIRITUALITY

A handful of the nation's medical schools have received a financial boost to offer medical students classes on the role of spirituality and religion in healthcare. The National Institute for Health Care Research and the John Templeton Foundation have announced offering $25,000 grants to eight medical schools. The money will fund courses on religious beliefs and the role of faith among the terminally ill. Potential doctors will be taught how to include a spiritual history in their diagnosis.[10,11]

Among the schools reported to participate are Brown University, the University of Chicago, the University of Rochester, and the Oregon Health Sciences University School of Medicine. At Morehouse School of Medicine, a predominantly African-American medical school in Atlanta, Georgia, a course is being planned that will pair medical students with terminally ill patients from the day of diagnosis to the day the patient dies. Students will also be involved in funeral arrangements. Regardless of the physician's personal beliefs, it is beneficial to know how to respond to patients' questions regarding life after death. However, any interpretations made or perspectives shared about a patient's world view should be done in the context of empathic respect for the patient's values. It is unconscionable to cause the patient to link sickness with guilt due to a failure of sufficient faith.

## AFRICAN-AMERICAN UNIQUENESS

There has been much written about the "paranoid" aspects of African-American personalities, but quite obviously, African Americans should never be diagnosed as paranoid until healthy suspicion has been considered.[12] My clinical observation is that symptoms frequently noted to be paranoid may be a utilitarian way of coping in a biased environment. In fact, the whole field of mental health requires realignment in terms of race and culture. A revision of thinking would challenge the cultural arrogance of racist ideology incorporated in western psychiatry. The DSM-IV has attempted to correct the cultural oversights and differences by including specific comments about culture, age, and gender features when describing psychiatric disorders.[13] This indicates that organized psychiatry has accepted the fact that there are differences in the manifestation of mental disorders in persons from diverse cultural and social groups.

Although supernatural and natural causes of diseases are mutually exclusive in many African-American religions, factors such as deterioration in a patient's condition may lead to reinterpretation of the cause, so that a natural cause is rejected for a supernatural one. Concepts of diseases and illness are learned in a variety of ways but largely through direct experience.[14,15]

African-American ministers often do not hesitate to discuss nosology and etiology of diseases with their congregations. Some ministers

are medically informed, whereas others hold to the belief that all forms of diseases, especially mental illnesses, are the result of sins. Physicians should therefore exercise discretion when seeking the input of some African-American ministers with patient management.

## CASE HISTORY 1—"I AM SUSPICIOUS OF THE MEDICINE"

Mrs. Gray is a 55-year-old widowed African-American female who was diagnosed initially by her family physician as suffering from depression and was placed on paroxetine HCl, 20 mg daily. After taking only one dose of the antidepressant, Mrs. Gray discontinued the medicine because it made her feel dizzy. Having failed to take the prescribed medication, and with continued symptoms of depression, she was referred to a psychiatrist.

With some trepidation about seeing a psychiatrist, Mrs. Gray indicated that her chief complaints were recurrent brief crying spells (two to three times a week), difficulty falling asleep, and a loss of appetite. She also had physical symptoms of numbness in her arms and hands, vague chest pains, and acute shortness of breath. There were no psychotic symptoms and no history of substance abuse. She stated with hesitancy that she had been informed that there was no physical basis for her symptoms. The referral affirmed there were no abnormal findings on physical and neurological examination. Additionally, there were no abnormal laboratory results. Mrs. Gray's TSH was normal, as was her electrocardiogram. Her past medical history was positive for essential hypertension, which had been controlled with diet and exercise. The diagnostic concern was whether Mrs. Gray's symptoms were caused exclusively by depression and if she also suffered from a panic disorder as medical comorbidity was not an issue.

After obtaining a psychiatric history, which also included information about religion/spiritual orientation, it was concluded that Mrs. Gray met the DSM-IV criteria for a depressive disorder with panic-like symptoms. She was advised to reduce her paroxetine to 10 mg each morning in an attempt to minimize side effects. Mrs. Gray politely agreed to resume her medicine but only after "the very next prayer meeting" at her church.

Ostensibly, the delay to take her antidepressant was related to Mrs. Gray's wishes to consult with her "prayer partners and for the group to touch and agree" before resuming the medicine, a traditional African-American religious concept in some Christian communities. It was encouraging to hear Mrs. Gray say that her pastor and her prayer group did encourage compliance with treatment. After 3 weeks without side effects, her paroxetine was raised to 20 mg each morning.

To appropriately respond to Mrs. Gray's emotional needs, it became necessary to transcend traditional Anglo-European treatment approaches, techniques of insight psychotherapy, vis-à-vis, growth through self-understanding and personality integration that resolve inner conflict. Whereas African Americans do respond favorably to most forms of psychiatric treatment modalities, Mrs. Gray was given authority-centered ethnic/cultural treatment because of her African-American fundamentalist orientation. She expected and received advice-giving counseling that focused on helping her solve the expressed psychosocial conflict. The pastor's encouragement and his acknowledged religious authority was extremely important to Mrs. Gray's compliance and treatment. I have observed that for some African Americans, group prayer services may provide sustained emotional support long after psychiatric treatment is terminated.

## CASE HISTORY 2—"I HAVE A LACK OF FAITH"

Ms. Jones is a 42-year-old divorced African-American female who recalls initially being sexually abused at 5 years of age by her 10-year-old brother. The abuse continued episodically to age 15. Throughout the years, she had complained to her mother but to no avail. Her

grandmother, who lived with the family, listened to her complaints but did not intervene.

Ms. Jones was reared in a religious (Holiness) family by her unwed mother, grandmother, an older sister, and the aforementioned older brother. At age 15, she ran away from home after concluding she could no longer tolerate the sexual abuse, the severe corporal punishment from her mother, and being forced to attend church. Upon leaving home, she began living with a man 15 years her senior, whom she did not know very well. He is described as being an alcoholic and subjected her to emotional and physical abuse. After 2 years in the relationship, she became pregnant and gave birth to a daughter. Several years later she departed with her daughter to live independently and worked at several unskilled jobs to survive.

By age 35, with aid from a federally supported job program, she obtained a GED and became a licensed practical nurse. Yet, Ms. Jones had been unemployed as an licensed practical nurse because of depression and multiple vague medical complaints. She occasionally experienced suicidal thoughts, but was restrained only because she believed there is no forgiveness from God for suicide.[16]

Ms. Jones was self-referred for psychiatric treatment after watching a television special on depression. During the initial interview, Ms. Jones stated that her problems were due to a lack of faith. She believed that her years of misfortune were because of past sins. She struggled to explain why her sister escaped the sexual abuse from their brother and the severe beatings from the mother.

Ms. Jones denied any previous psychiatric treatment. She was on no medications. Although overweight by approximately 30 pounds and having vague abdominal cramps, she considered herself to be in good physical health. A systems review failed to uncover any significant physical problems. There was no history of alcohol or drug abuse.

Ms. Jones frequently experienced frightening dreams of being sexually abused. She admitted to sleeping with a hammer beneath her bed because of fear of being assaulted by an intruder. There were intrusive thoughts about her mother's predictions that she would never succeed. She avoided being in the company of others for fear of being exploited. She experienced episodic crying spells, and insomnia had been a major problem for years.

Ms. Jones manifested symptoms of posttraumatic stress disorder (DSM-IV), that also included vague gastrointestinal difficulties, a phenomena I have noted among many mood-disordered African Americans. She was placed on an antidepressant, sertraline HCl 50 mg per day, and seen individually weekly. She was encouraged to help me understand her concept of "a lack of faith," something she had spoken of during intake interview. She seemed surprised, yet pleased, when I asked about her religious faith and practices. She was also eager to discuss her lack of church participation, indicating the lack of church attendance had been of concern. She believed that only through divine forgiveness would she find happiness, despite psychiatric intervention.[17,18]

The unrecognized guilt related to sexual abuse and anger for her mother were issues that were explored with sensitivity and respect. Ms. Jones's recovery was slow, requiring months of individual supportive, cognitive behavioral, affirmation techniques, and pharmacotherapy. Crucial to recovery was a clearer understanding that there was no correlation between the abuses of the past and her religious beliefs. Her sertraline HCl was eventually raised to 150 mg each morning. Group therapy was recommended after 6 months of individual therapy and only after she became less apprehensive in the presence of others. Ms. Jones was in treatment for a total of 2 years before she could engage in productive employment as a licensed practical nurse.

## CONCLUSION

There does appear to be a positive connection in the relationship between religion/spirituality and health, as the early research find-

ings from Duke University, the University of California, Harvard, and the University of Michigan have revealed.[19] Studies within the last 2 or 3 years from these institutions have been done well, using state-of-the-art statistical methodology. Yet medicine must continue to proceed quite cautiously as researchers gain better control for factors of stress, social support systems, and improved health habits within the general population.[20]

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