CHAPTER 3.1

Religious Experience and Psychopathology

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3.1.1 INTRODUCTION

Even though medicine and psychopathology, on the one hand, and theology on the other, deal with fundamental aspects of the human condition, they are separated from each other for methodological and ideological reasons. Very often, from the psychiatric perspective, religious phenomena have been considered in a one-dimensional and too superficial way, often considering them just as symptoms of a major psychiatric disease or traits of an insufficiently developed personality.

Therefore it is not surprising how little future physicians are taught to explore the religiosity of their patients. Although the fact is that religiosity can be an important factor in clinical decisions and religious perspectives, for many individuals, it is one of the most relevant aspects of values attached to clinical circumstances.

3.1.2 PHILOSOPHY AND PSYCHIATRY

Psychiatry needs philosophy because mental patients are confronted with philosophical problems: For instance, delusions in patients suffering from schizophrenia are the result of concerns about the sense of life and the raison d’être of nature. The Spanish psychiatrist Sarro [1] for many years studied the theme of delusions, mainly in patients with paraphrenia, and came to the conclusion that they corresponded with the themes of myths in ancient cultures. He coined the term mythologems to described such themes (initially 12 but the number increased slowly to up almost 100) which were the expression of the answers that we human beings give to the mysteries or enigmas of nature. Examples of mythologems are fantastic genealogies, such as when a patient believes he belongs to a royal family, or like a patient we had, who believed they were the descendant of a long genealogy of stars starting
with Antares and followed by Anteritis, and so on; the creation and destruction of the world, such as when a patient keeps his fist closed all the time because if he opens it, the world will disappear, a delusion reminiscent of the myth of Atlas holding up the globe of the world; the fight between good and evil, in which the patient may be the protagonist; immortality as in the délire d’immortalité of Cotard; the ourobouros, the androgynus and so on.

Other patients also have philosophical concerns: those suffering from depression, with the meaning of loss and death, neurotic personalities with an exaggerated sense of their own existence, psychopaths with social order, and so on. The problem with patients is that they reach solutions that are candid and subjective. In the words of Bilz [2] patients take the pars pro toto (a part for the whole), a phenomenon also analyzed in the stereotyped movements of patients with schizophrenia [3] and by Fuchs [4, 5] in body dysmorphic disorders, characterized by a disturbance in the relation to others manifested by an inability to take a meta-perspective.

As a consequence, the thoughts of the melancholic patients are centered on suicide, of those with schizophrenia on a delusional interpretation of reality, of those who are neurotic on inhibitions and of psychopaths on nothing but their impulses. The philosopher and the same person, on the contrary, seek the sense of all of that is beyond concrete circumstances. In his Anthropology the philosopher Immanuel Kant [6] devotes several pages to madness (Verrücktheit) and its different forms. The common thread to all of them is ‘the loss of common sense’ (sensus communis), when somebody’s ‘stream of thoughts follows its own rule, which is contrary to that that conforms to the laws of experience’. Similarly he describes someone who is ‘dull’ (Schwach) as lacking intelligence which is the ‘faculty for discovering the universal from the particular’.

3.1.3 DEMONIAC ILLNESSES

The history of medicine is the history of natural explanations to phenomena considered up to the moment as supernatural. About 2000 years ago Hippocrates, father of medicine, defended what we nowadays call epilepsy or still hiëra nosos (Greek), morbus sacer (Latin) or morbus demoniacus (the demonic sickness), was but an illness not more nor less sacred than others. The quote of Hippocrates [7] still merits attention:

It is thus with regard to the disease called Sacred: it appears to me to be nowise more divine nor more sacred than other diseases, but has a natural cause from the originates like other affections. Men regard its nature and cause as divine from ignorance and wonder, because it is not at all like to other diseases. And this notion of its divinity is kept up by their inability to comprehend it, and the simplicity of the mode by which it is cured, for men are freed from it by purifications and incantations. But if it is reckoned divine because it is wonderful, instead of one there are many diseases which would be sacred; for, as I will show, there are others no less wonderful and prodigious, which nobody imagines to be sacred. The quotidian, tertian, and quartan fevers, seem to me no less sacred and divine in their origin than this disease, although they are not reckoned so wonderful. (...) Such persons, then, using the divinity as a pretext and screen of their own inability to of their own inability to afford any assistance, have given out that the disease is sacred, adding suitable reasons for this opinion, they have instituted a mode of treatment which is safe for themselves, namely, by applying purifications and incantations, and enforcing abstinence from baths and many articles of food which are unwholesome to men in diseases.
This brings with it the notion that all natural illnesses may also have something supernatural, that is to say, a meaning beyond the merely biological, which is what humanism brings into medicine.

In spite of this, for centuries the names given to this illness in medical terminology and in the vernacular throughout the various historical epochs are an indication of the believed relationship between epilepsy and the supernatural: the holy illness, *morbus divinus* (the divine), *morbus deificus* (created by God), *morbus coelestis* (the heavenly illness), *morbus astralis* (the stars illness) and *morbus lunaticus* (the moon induced illness).

In Germany in the Middle Ages, a large number of colloquial expressions for epilepsy illustrate the influence of supernatural and divine forces and the ‘falling sickness’: *Zuchtrute Christi* (rod of Christ), *Gewalt Gottes* (power of God), *schedelnde* (*schüttelnde*) *Gottesstraf* (shaking punishment from God). Even the term ‘*Gichterle*’, used to describe epileptic fits suffered by small children, which is still a very common expression in Southern Germany, refers to the supposed supernatural (albeit demonic rather than divine) cause of the illness: ‘*gichtige Krankheit*’ (‘*Gichterle* is a diminutive of this term) means something like ‘illness passed on through witchcraft and magic’.

According to popular Christian piety in the Middle Ages, God had both the power to inflict epilepsy on people (as punishment, penitence or test) and to liberate them from it. Thus, relief from this illness was more likely to be obtained from God, rather than from a physician, and from Christian faith, rather than from medicine. In addition to Christ himself, saints were also frequently called upon to assist in combating the ‘falling illness’. In *Hagiotherapy* (‘treatment with the sacred and with saints’) there were qualified ‘epilepsy specialists’, the most important of whom – in the German-speaking world – was Saint Valentine, who has remained so until today. The Valentine patronage of epilepsy is probably attributable to the name of the saint: ‘Valentine’ has a phonetic similarity (albeit no etymological relationship) with the German word ‘fallen’ (to fall): Valentine = ‘fall-net-hin!’ (don’t fall down!), is a popular wish for people prone to fits. The sentence ‘He must be having a Valentine’s day today’ is still used in the vernacular nowadays to refer to a person who has dropped something for the umpteenth time.

For the linguistic reasons mentioned, it is understandable that in countries with a Christian tradition, in which German is not spoken by the majority of the population, Saint Valentine scarcely played a role as patron of the falling sickness. In France, for example, Saint John was an important helper in the fight against epilepsy (*mal de Saint Jean*), and in Anglo-Saxon countries, especially in Catholic Ireland, it was Saint Paul (*Saint Paul’s disease*).

In India, ill people frequently call upon the powerful god Shiva, who can bring and send away illnesses. In ancient India ‘*apasmāra*’ was an evil epilepsy god. In the ancient Indian medical Caraka script (6th century AD), the name of this demon is used synonymously with the illness ‘epilepsy’. Four ‘*apasmāra’ variations* (four different types of epilepsy) with varying symptoms were described, and the dancing god Shiva can help to relieve all of them. The Aztec goddess Tlazolteotl was also able to bring about epilepsy or to spare people from it. By penetrating human beings, she could send them into convulsions.

### 3.1.4 WITCHCRAFT AND MENTAL ILLNESS

In the sixteenth century, a time when central Europe reached its peak in burning witches at the stake, Johannes Weyer (or Wier) [8] said that these were but ‘*poor melancholic women*’.
I have therefore chosen to present this story in order that they [those who object to my work] and all others may look upon such tricks with a clearer mental vision and not allow themselves so rashly to be deceived by this illusion, this clouding of their eyes. I do so in order that they may not remain like blind moles in the filth thrust upon them by the demon, but that they may rather allow the cloudy spots or the film to be cleared from their pupils by a physician who offers this salve free of charge to all who wish their eyes to be clear and free of the spirit that dims them.

Already before Weyer, the inquisitor Alonso de Frías ended the pursuit of witches in Spain during the second process of the Spanish Inquisition, claiming they were just ill people [9]. Stories of slaughtering children and macabre witches’ Sabbath ceremonies began to spread at the beginning of the year 1610. The inquisitor Juan Valle Alvarado in Zugaramurdi (in Navarre, north of Spain) received many charges based on these stories. With the help of Alonso Becerra Holguín and Alonso Salazar Frías he promulgated a sentence of 53 condemnations, 11 of them to be burnt at the stake. Five of the death penalties were executed. However, Alonso de Salazar y Frías, gave a special vote and obtained authorization to review the process. He examined 1384 children and 420 adults, he collected the potions and gave them to animals in order to find out if they were lethal, he planted secretaries of the court in the places where the Sabbaths were celebrated to verify if indeed they met on the dates of their demonic parties, he even ordered that supposedly offended young girls were subjected to medical examination. The results proved the harmlessness of the potions, the solitude of the places and the virginity of the women. Moreover, he concluded that the declarations at the court were the product of suggestion and that therefore they lacked evidence. Salazar de Frías prepared a long report that he sent to the Supreme Inquisitorial Council after which, on March 26, 1611, an edict of pardon was announced by Decree. Juan de Mongastón gave an extremely detailed report of this court procedure [10].

### 3.1.5 PSYCHOPATHOLOGY AND SUPERNATURAL PHENOMENA

Science in general and psychopathology in particular, have given greater and greater consideration to natural phenomena as the most important part of supernatural subject matters. The end point of this process is the rejection of religiosity, which if it remains, is only as an expression of a human necessity. In the words of *Si Dieu n’existait pas, il faudrait l’inventer. Mais toute la nature nous crie qu’il existe* (‘If God did not exist, it would be necessary to invent him. But all nature cries aloud that he does exist’) [11] and Freud is believed to have shown how this invention became possible, based on the similarity of religiosity and the scruples of obsessive neurosis.

Obsessive neurosis was for Freud a form of individual religiosity and religiosity, a collective obsessive neurosis. In both cases the origins are the scruples, a defensive psychological mechanism that aims to control anxiety, individual in the first case, collective in the other. For Freud and many others, religion is a metaphor of mental illness [12].

However, this approach fails due to its reductionism. Scruples of conscience of obsessive neurotics are the expression of a subjective morality, that gives priority to the cleanliness of a person’s own conscience. This is the antithesis of religious phenomena which always transcend the individual. Again, we have the *pars pro toto* phenomenon.
A similar circumstance is the case of those who suffer scruples of cleanliness, who may even not wash themselves fearing to get dirty, ending up suffering from a notorious lack of personal hygiene. In both cases obsessive rituals serve only a limited goal and are the expressions of a behavior pattern more likely of a magic spell than of a real search for perfection.

Clinical psychiatry and the rest of medicine are loaded with religious phenomena and experiences. In neurosis there is a lack of sense of one’s own existence. To Jung, neurosis ‘must be understood, ultimately, as the suffering of a soul which has not discovered its meaning’ [13]. Similarly, in depression the problem of death recurs once and again, but schizophrenia is the ‘religious’ illness par excellence. The delusional schizophrenic patient creates fantastic worlds, full of symbols and new meanings which in some cases become striking apocalyptic visions. So much so that frequently it has been considered that shamans and visionaries from other cultures would have been diagnosed with schizophrenia in our culture. For the physician these religious phenomena are nothing but symptoms, that is to say, signals of an underlying pathology whose significance the physician is unable to explain. It has also been stated that people with schizophrenia are but failed genius in a society that does not tolerate their revelations and needs the complicity of psychiatrists to silence them. Last but not least, the physician has to face up constantly to what has been called the scandals of pain and death.

3.1.6 DELUSION AND RELIGIOUS EXPERIENCE

In this context it is clearly shown how coarse it is to compare delusional ideas of patients suffering from schizophrenia, for example, with mystic or religious revelations, however apocalyptic or innovative they may be. Delusional ideas are individual and therefore frustrated truths. They start and end at the delusional person; they are not oriented towards somebody else. Patients with schizophrenia never share their delusions and hardly ever their worries. Their isolation comprises not only the world of the sane but also of their kind. Delusions are the replacement of common sense by a very private sense and a way to fulfil the need to communicate of every human being.

Phenomenological and existentialist influenced psychiatry has described how delusional ideas consist of the desire to control one’s own world, idios kosmos, or the common world, koinos kosmos [14]. Each one of us is in two worlds at the same time, the one of common reality and one’s own in which fantasy, dreams or simple longings and hopes reign. The sane person is able to distinguish one from another, and even to pass from one to another even when doubts about that radical ambiguity of our consciousness assault him or her. In delusions everything is different. Not able to live in a koinos kosmos, the patient substitutes and misappropriates the idios kosmos in such a way so as to not be able to distinguish what is what. All this is carried out accompanied by a deep sense of drama hard to perceive during a superficial treat that only states social withdrawal or a state of emotional dullness, but that can be seen in pictorial productions, in some psychological tests or in a deeper relationship. The brilliant, innovative man, creator of new worlds feeds in an idios kosmos, but immediately communicates it, drags others to participate in it and recognize in themselves the creating force. Truth with capital letters, enriching as a contrast to the private truth of the delusional individual that is but the dramatic effort to reach a truth illness denies.
3.1.7 THE PROBLEM OF TRUTH IN PSYCHIATRY

Truth and falseness are a core aspect of psychiatry, but psychiatry sometimes forgets the problem of truth [15]. Let’s start with a common example. One of my first patients was a middle aged German psychiatrist who suffered from schizophrenia. His voices were very painful as they ordered him to have intercourse with his father when visiting him at the hospital and acts of a similar nature. As I tried to reassure him saying that the voices were just irritations of his brain cortex due to his illness, he answered: ‘I see that you are still young in the profession, patients with schizophrenia patients say that they hear voices, but mine are true’.

Heinroth [16] wrote in 1824 Über die Wahrheit (On the Truth) and made outstanding distinctions on the subjective versus the objective truth and on the behavior of human beings towards the truth versus the behavior of the truth towards human beings. Since then very little has been published on the subject, in spite of the fact that delusions are commonly conceived as false beliefs.

3.1.7.1 Conventional definitions of delusions

In DSM-IV [17] a delusion is defined as: ‘A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everybody else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person’s culture or subculture (e.g., it is not an article of religious faith)’.

The origins of this definition can be traced to over two hundred years ago: ‘Error in the ability to judge, fantasise without fever or disturbance of the consciousness’ [18], ‘false and pathological ideas’ [19]. During the nineteenth century in France these definitions were elaborated into: ‘A delusion is a false idea, of pathological origin, highly resistant to logical arguments and which alters the judgement of reality’.

The outcome of this perspective was interest in the content, in the themes of delusions leading to an endless list of delusions (reference, influence, persecution, control, jealousy, erotic, guilt, ruin, nihilistic, hypochondriac, grandiosity, messianic, induced, etc.).

Karl Jaspers [20] investigated these definitions and established three main criteria for a belief to be considered delusional: certainty (held with absolute conviction), incorrigibility (not changeable by compelling counterargument or proof to the contrary) and impossibility or falsity of content (implausible, bizarre or patently untrue).

In spite of the fact that all the characteristics mentioned have been criticized, the approach to define delusions just described has survived for centuries and is accepted as standard teaching all over the world. There are two reasons for this. The first one is very pragmatic, and has to do with the value that they have for diagnosis in everyday clinical practice. It follows that they are also useful for ancillary purposes such as management, communication with other physicians and for forensic issues. The second reason is more subtle, psychiatrists are able to recognize in an immediate way delusional phenomena, but they need a structure of thinking, a frame, on which to phrase their clinical intuitions [21].

The role of intuition for the diagnosis of schizophrenia was described several decades ago under the name of ‘Praecoxgefühl’ [22], literally, the feeling of schizophrenia. The fact that a psychiatric diagnosis is not an exclusive rational endeavor was also underlined by the term ‘Gefühlsdiagnose’ [23], affective diagnosis, to be carried out at an emotional level.
This approach allows grasping the expressivity and depth of the person before any analytical desegregation in parts and symptoms. It is a diagnosis not through the feelings but with the feelings.

The above mentioned definitions have often been criticized, Schneider being the first one to do so in depth [24]: Falseness is relative and an accessory (individual and cultural aspects); pathological origin is a vicious circle argumentation; absolute evidence and incorrigibility. *There are errors more obstinate than delusions* [25].

### 3.1.7.2 The falseness and impossibility of delusions

Delusions do not necessarily have to be false or ‘incorrect inferences about external reality’. Some religious or spiritual beliefs (such as ‘I believe in the existence of God’) by their nature may not be falsifiable, and hence cannot be described as false or incorrect, no matter whether the person holding these beliefs has been diagnosed as delusional or not [26].

In other situations the delusion may turn out to be true belief [27]. For example, delusional jealousy may result in the faithful partner being driven to infidelity by the constant and unreasonable strain put on them by their delusional spouse. In this case the delusion does not cease to be a delusion because the content later turns out to be true.

In other cases, the delusion may be assumed to be false by a doctor or psychiatrist assessing the belief, because it seems to be unlikely, bizarre or held with excessive conviction. Psychiatrists rarely have the time or resources to check the validity of a person’s claims, leading to some true beliefs to be erroneously classified as delusional [28]. This is known as the Martha Mitchell effect, after the wife of the attorney general who alleged that illegal activity was taking place in the White House. At the time her claims were thought to be signs of mental illness, and only after the Watergate scandal broke was she proved right (and hence sane).

Another difficulty with the diagnosis of delusions is that almost all of these features can be found in ‘normal’ beliefs. Many religious beliefs hold exactly the same features, yet are not universally considered delusional. According to Thomas Kuhn scientists can hold strong beliefs in scientific theories despite considerable apparent discrepancies with experimental evidence [29]. These factors have led people to note that ‘there is no acceptable (rather than accepted) definition of a delusion’ [30].

### 3.1.7.3 The structure of delusions

According to Gruhle [31] if the content can not help to distinguish delusions from everyday beliefs, the answer is to be found in the structure of thinking while deluding. He came to the conclusion that what characterizes delusions is that an abnormal meaning is given to an up to then normal perception. Although many different sorts of delusions have been described, all are either delusional perceptions or delusional intuitions [22]. Perception is the process that allows people to interpret and to organize sensations in order to generate an experience of the world, where the individual can safely live and survive. This experience is both meaningful and emotionally loaded, because both aspects are an essential component of the world for each of us. Delusions are perceptions without a motive [30], implicating that there is no understandable connection between the perceived reality and the meaning accorded to it. The abnormality in the attribution of meaning was considered as a lack of
Sinngesätzlichkeit (lit., absence of sense of legitimization), what in essence was a form of recognizing Jaspers’ incomprehensibility [32]. In delusional perception he described two arms of perception: 1) The object is perceived and 2) The meaning is attached to the object. In delusions, the meaning, often self referred, is imposed by the object (the meaning is in the object, that’s why it cannot be discussed).

Schneiders’ goal in these descriptions was basically diagnostic. For instance he was much against considering first rank symptoms, that is to say, symptoms leading, in the absence of a brain disturbance, to the diagnosis of what I call schizophrenia, as primary symptoms (basic symptoms from which others can emerge).

Hillman [33] in a deep analysis of Freud’s Schreber case reaches the conclusion that the process of thought in delusion is not different from the normal process of thinking. The delusional individual builds his world and fills it with meaning the same way as the ordinary person does. The difference is in the individual who is delusional. In the same way Ey [34] commented as a conclusion of his monumental work ‘Les hallucinations’ that the hallucination does not exist, only the person hallucinating.

3.1.7.4 The Many Meanings of Truth

Truth is not a univocal concept. For our purposes let’s take only two of them. For the philosopher Ferrater Mora [35] there are two concepts of truth: 1) truth as opposed to error ($2 + 2 = 5$ is not true because it is an error); and 2) truth as opposed to illusory (the moon is populated by selenites is not true because it is unreal). Furthermore, there are important cultural aspects of truth. In the Old Testament and in the Semitic tradition truth is the acquiescence to God’s will, which is typified by the word amen. In Ancient Rome the concept depended on verification, true is what is real, and the word that represents it is veracity. In all these distinctions the attitude toward truth, already considered by Heinroth, is present.

The most accepted concept of truth is the one put forward by Aristotle in his Metaphysics. It is so alive that attempts to rethink modern logical questions with Aristotle’s eyes can be accepted as valid [36]. From the Greek philosopher’s perspective, truth is a matter of being isomorphic (concordant) with the external world. The origin of the correspondence theory is that it is a theory on which the truth of an assertion consists in its correspondence to reality. ‘To say of what is that it is not, or of what is not that it is, is false, while to say of what is that it is, and of what is not that it is not, is true’. Aristotle also added that ‘Falsehood and truth are not in objects . . . but in Logos’. Although Logos is often translated by thought or reason, it actually means thought and speech. Intellectus ex sua natura est locuturus (Thought is by its own nature speech) [37]. Therefore, if delusions are thought disorders, they are also disorders of communication and delusions and hallucinations have more in common than usually accepted, as we will see later.

For Heidegger [38] there a concept of truth which is older and lies beneath the Aristotelian one. It is truth as aletheia, a term used by pre-Socratic philosophers with the meaning of revelation. Aletheia ($\alpha\lambda\theta\epsilon\iota\alpha$) means ‘the state of not being hidden; the state of being evident’, in short ‘disclosedness’ from lethe ($\lambda\theta\eta$) ‘forgetfulness’, ‘concealment’.

The fact is that truth is hidden and needs to be manifested as expressed in the aphorism of Heraclitus [39]: ‘Nature likes to hide’ is sometimes translated as ‘Nature hides zealously its secrets’.

From then on Heidegger identifies truth with the freedom not to interfere, not to impose, the freedom of letting things (and human beings) be what they are, in a process that occurs in
an interpersonal relation. That is why thinking and saying go together as in the word logos. Therefore, the falseness of the delusion is at the same time a lack of freedom and a lack of communication. Truth, freedom and love are notions that go together. On this line, Blankenburg [40] has studied the writings of a patient which were very similar to poems of Rilke and raised the question of the difference between them. The conclusion is that the difference is not in the poems themselves but in the attitude of the authors. The patient may abandon, throw away or use the piece of paper to wrap something in, while Rilke collects the poems with others and brings them to his publishers so that others may read them.

In clinical settings truth is not a fact but a process which reaches the point where the truth of the patient and the truth of the doctor coincide [41].

Heidegger’s points of view have, although on very different levels, striking similarities with psychoanalysis. The process of reaching truth, of recovering memories, of giving them a meaning, of incorporating them in one’s own biography, as in Freud’s expression was Es war soll Ich werden (the Id should be replaced by the Ego) [42] is a process of revelation which occurs in the doctor-patient (or analyst-client) relationship. Here the first principle lies in transference-countertransference, the second in not interfering with the patient’s autonomy [43].

The issue of truth in psychoanalysis has been raised by Lorenzer [44], who asks himself if psychoanalysis can discover the truth getting to know concrete persons?, following Feuerbach’s notion: the nature of human being is no abstractum inherent to each individual. In its reality it is the ensemble of social circumstances. For Lorenzer, the question of truth is the key problem of the theories of knowledge and of political theories (is psychoanalysis going to break the traditional stability of society?).

There are strong, although unrecognized, Hebraic roots in Heidegger’s propositions [45]. For instance, the poet in the German philosopher’s writings, is the one who discovers and manifests the truth, he is a creator (poet derives from the Ancient Greek poiesis, ‘creation’). This is exactly what the prophet does for the group of faithful, recreating for them truth hidden in the sacred texts.

In a similar way Bakan [46] has found non explicit connections between Freud’s writings and the mystic Jewish tradition and López Ibor with Gnostic beliefs and perspectives [47].

Popper [48] has identified the three principles for the search of truth: 1) The principle of fallibility (maybe I am wrong and maybe you are right but, of course, we may both be mistaken); 2) The principle of rational dialogue (we want to critically prove our reasons in favor and against our theories. This critical attitude to which we are obliged to adhere, is part of our intellectual responsibility) and 3) The principle of approach to the truth with the help of the debate (we can almost always approach truth with the help of impersonal critical and objective discussions, and like this we can almost always improve our understanding, even in those cases where we do not reach an agreement. We need others to discover and correct our errors and above all, we need people educated with different ideas, in a different cultural background. Like that we achieve tolerance).

### 3.1.7.5 Recent perspectives on delusions

As we see, falseness is not a valid criterion as a delusion can be true and still be a delusion. In order to avoid this problem DSM-IV-TR introduces a caveat, ‘delusions persist despite the evidence to the contrary and these beliefs are not ordinarily accepted by other members of the person’s culture or subculture’. But delusions are not beliefs [49] and therefore, it is
necessary to look for definitions based either on the structure of delusions or on the process of becoming deluded and not merely on the content of delusional phenomena. More recently, delusions have been characterized not by the falsity of their contents, nor by their abnormal structure, but by the attitude of the person towards the perceived reality (Hilma, 1987; Stephens and Graham 2004). For Sass and Parnas [50] delusions are characterized by two complementary distortions of the act of awareness: exaggerated self-consciousness in which aspects of oneself are experienced as akin to external objects (hyperreflexivity) and a weakened sense of existing as a vital and self-coinciding source of awareness and action (diminished self-affection or self-presence). These characteristics are present across positive, negative and disorganization symptoms and are the expression of the distortions of consciousness and the sense of self that are present in delusional activity.

Let’s suppose the case of a person with a delusion of jealousy: a man thinks without any reason that his wife is being unfaithful to him and as a result of this conviction he starts to keep watch on his spouse and to interrogate her repeatedly and to seek time and time again for proof of her perfidy. Taking into account the classical definition of delusion as a false idea the cure of the delusion would be very simple. In the words of De Clérambault: ‘plût au ciel, Monsieur, qu’il suffise d’être cocu, pour n’être point malade!’ (God’s will, Sir, that it would be enough to be a deceived husband, not to be ill) [51]. If not, it would be enough to tell the wife to really deceive her husband and then, since the infidelity now is real, the feelings of jealousness would not be delusional anymore. Leaving aside this grotesque advice, it happens that it does not work. From time to time, a woman who is being extremely harassed by a jealous husband may confess what she has not done only to put an end to her husband’s delusional pestering. When this happens the delusion does not disappear, it becomes even larger and possibilities for treatment decrease.

The delusional idea does not have to be false and a normal structure does not guarantee that all our ideas are correct. John Nash, was asked by one of his colleagues how such an intelligent man like him could have been able to think during the moments he had delusions, that the inhabitants of the moon and the communists were all against him. He answered: *The ideas I had about supernatural beings came to me the same way that my mathematical ideas did. So I took them seriously* [52]. He also analyzed the mathematical thinking of his great colleagues at Princeton and he reached the conclusion that the mathematical ideas and intuitions of his colleagues had, on many occasions, the same structure as his own delusional ideas [53].

The discovery of truth and freedom are linked together and are part of a very religious discourse: I am the truth and the life; when two of you are talking about me I am there in the middle; truth will make you free, are sentences found in the New Testament.

### 3.1.7.6 Personal concerns of clinicians and researchers

On the other hand, it is clear that every scientist has deep personal concerns over these basic questions to which I am referring, as many of them have recognized when undergoing the discipline of a strict methodology which is, above all, the safeguarding of errors and absolutism. When Kuhn [54] mentions that the problem of truth is of no interest for science but only for distorted propositions, that is to say they can be refuted since they are only provisional, he is describing an attitude from scientists that does imply a search for the truth, in the sense I referred to above and the ascertainment that it is an unlimited process. In this
sense the personal relationship of the scientist with truth is uneven. Freud was a radical agnostic as can be deduced from his autobiography and from the testimonies his disciples have revealed.

Moving away from this perspective it is possible to say that science does not exist in a world of values, it is possible for the psychopathologist to find enriching perspectives in religious texts, which is the contrary to despising them as metaphors of an illness. In my understanding, science is part of a certain sense of transcendence that is sometimes mistaken with an ideal of material well-being and technical progress or, in more pessimistic times like nowadays, of technical resources to solve the problems raised by technique.

3.1.8 PSYCHOPATHOLOGY OF BEAUTY AND GOODNESS

Science in general and pathology in particular have developed eluding, when not denying, basic questions, that is to say what refers to truth, goodness and beauty and their opposites. However, these questions come to the surface time and time again in clinical practice. Here are some examples.

The first one is the body dysmorphic disorder where patients seek plastic surgery for the correction of a supposed deformity that has become a stigma whose presence is feared for what it can reveal about them. In a certain way it is more an ethical problem than an aesthetic one, or better said, physiognomic, in the sense of physiognomy, as the revelation of a hidden essence [55]. These patients remind us of the Greek ideal of goodness linked to beauty, both inseparable, of a beauty that is so because it reveals the best of the individual. This disorder is also known as the Thersites complex [56], because this minor character of the Iliad, described as lame and deformed, as well as wicked and evil.

3.1.8.1 The cosmetic of the personality

Cosmetic or palliative pharmacotherapy is to use a psychotropic agent to make a person who is not ill feel better. It usually intends to mitigate unwanted or unaccepted psychological traits in order to attain a higher order of social normality and acceptability. The issue was raised by Kamer [57] who described how fluoxetine used for the treatment of depression and for other psychiatric disorders was able to eradicate some personality traits also present. He looked at traits previously considered as an expression of human miseries or, in some cases, as the consequence of negative childhood experiences. Kamer even questions whether there could be a ‘pandemic’ of cosmetic psychopharmacology which would lead to the disappearance of phenomena, such as anguish, which are essential for personal realization in the arts, religion, and creativity.

Cosmetic and plastic surgery is most often than not carried out in people who do not fulfil criteria for any disease. The interventions in this area are not always necessary from the clinical point of view. But in the case of some psychiatric disorders the situation is different. The fact is that people without a recognizable disease can benefit from a psychotropic drug. Fluoxetine can make non depressed people feel more vital, mentally more alert and therefore more popular, leading to an increased feeling of wellness; shyness became a treatable illness when paroxetine was introduced to treat social phobia and atomoxetine can change the life conditions of adults with a history of Attention Deficit Disorder with
Hyperactivity. Subthreshold depression or personality disorders are not just ‘non disorders’. The first are a consequence of modern diagnostic criteria and, taking into account that they represent a risk of developing ‘clinical depression’, it seems wise to provide these people with antidepressant treatments. The relief of depressed mood makes the person feel better and the reduction of anhedonia makes him or her enjoy life more, even if those symptoms were present in a subthreshold intensity.

The case of personality disorders is similar. Those are not just variants of the personality; they are ‘real disorders’ which may benefit from antidepressants or other treatments. All this may lead to a change in diagnostic habits, lowering thresholds or modifying diagnostic criteria. For instance, the DSM criteria of suffering or disablement are value loaded, and new values, such as well-being may be introduced. But in other cases it may be different. Recently, there has been news on ‘doping’ by musicians, actors and politicians who use beta-blockers to fight stage fear as a substitute for alcohol, following a paper in *The Lancet* [58]. Doping is banned in sports, but not in performing arts or activities.

Although, we are not dealing with recreational uses, as these drugs have no effects on normal psychological conditions, the issue is, if the role of physicians is only to take care of a patient what is wrong with them asking themselves how they could improve things for a patient.

The words of Plato in Gorgias [59] are worth remembering:

> Beneath medicine, therefore, as I’m saying, lies the flattery of cookery; and beneath gymnastic, according to this same manner, lies cosmetic, in that evildoing, deceitful, ignoble, and unfree, deceiving with shapes, colours, smoothness, and garments, so as to make them, as they take upon themselves an alien beauty, neglect their own beauty that comes through gymnastic.

The problem of good and evil does not exist in science, not even in one such as anthropology, since, in a certain way, the less rational aspects of human beings have been recovered through the modern notion of human nature. Freud observed that human beings always knew they had consciousness, but that his own task consisted in demonstrating that there were also basements in the house. The eagerness was to recover them, in accordance with the expression wo es war, soll ich werden (‘where Id was, Ego should to be’) [60]. The goal of psychoanalysis is to convert neurotic symptoms into common human miseries, that is to say, into conscious ones. According to Lillian-Robinson [61] there is an overlapping between the concepts of neurosis and sin, in the same way that there are philosophical concepts like the fall (Verfallenheit in Heidegger) which refer to the risks that assault us; ‘ab inferos’ which individuals and the species strive to overcome time and time again.

### 3.1.9 THE MEANING OF ILLNESSES

The person who falls ill is normally confronted with two strangers: death and their own body. We experience our body (body experience or *corporality*) that has up to then been silent or as a mere presence, since we only get to know our body when we demand too much (tiredness) or when during illness its functions fail. Outside this we perceive the world and our activity in it, but not our organs and limbs that perform these activities. Also, patients are
faced many times with personal truths denied up to then. Each time more and more illnesses are known that develop from damaging behaviors which, however, are most common (overeating and drinking, dependencies, that is to say, slaveries to an endless number of substances or to certain activities, like gambling or even working). Businessmen, slave to the demands of their performance and efficacy, who are admitted to a coronary unit due to an acute heart attack, are faced with a truth up to then denied, ‘arrogantly denied’ and known by everybody, with the threat of needing to undergo a drastic change in their lives, without knowing how. This arrogant denial is the nucleus of the concept of madness in Classical Greece, the one that lead Oedipus to blind himself when he finally recognized himself as the parricide of Laius [62].

It has been said that a mute medicine was born with Hippocrates, a medicine full of facts and data and but not of words. However, since the end of the nineteenth century, especially after the first works of Freud, the word has been recovered for medicine. Ana O. referred to Breuer’s method of treatment as the talking cure [63]. This process is a deeper process than is usually admitted. In this sense, medicine, which I will call anthropological to simplify (the one that incorporates those concepts to which I am referring to), is a link between those sciences whose vision of nature is unilateral, despite their technical efficacy and philosophy and theology. The perspective of sciences is one-dimensional. This is why Marcuse [64] could refer to modern man with that same expression. In my opinion, deep down sciences come from the secularization of the gnostic thought, which is above all dualistic. Cartesian dualism, the differentiation of the *res cogitans* from the *res extensa* expresses a way to think of old tradition. From a methodological point of view and also from a technical one dualism is efficient, from there its success and the impressive scientific heritage accumulated by Western culture since the beginning of Modern Age [65]. This perspective is unidimensional and therefore not free from risks, from there comes the crisis of Western thought whose peak occurred after World War II.

### 3.1.10 DEEP PSYCHOLOGY

Parting from these facts, some psychotherapists have recognized that deep psychology moves in a religious field which is not the same one as religion, or that both of them share the same spirit of surmounting, of coming back to the roots and of seeking for the truth to which I referred before. Fromm refers to a common nucleus in the ideas, norms and teachings of Lao-Tse, Buda, the Prophets of the Old Testament, Socrates, Jesus, Spinoza and the philosophy of the Age of Enlightenment. The religious perspective refers to another world, while psychiatry and medicine in general refer to facts from this world. The promised liberation is therefore more risky for medicine since it has to take place here and now. Disappointment and a negative social attitude emerge easily against this liberation when it does not fulfil the promises or expectations it has created among the population. It is the so called medical nemesis [66]. However this dichotomy is not correct. Christianity is not a religion of two worlds, of a celestial Jerusalem and another earthly one. This is precisely what appears in some schizophrenic delusions to which I referred before, but to a Reign of God which is already in this world. This, of course, is very well known by theologians and mystics and Saint Teresa [67] expressed it precisely: "Entendido que, si es en la cocina, entre los pucheros anda el Señor" (‘please understand that, if in the kitchen, God is among the stew pots’). This explains the great analogies that exist in language between health and
going to heaven safely and the way in which a physician has a somewhat religious role and the pastoral somewhat healing role. Once medicine has recovered the word, the differences between both of them are even less.

Out of the religious and psychopathological phenomena that raise more questions in common, anxiety is to be highlighted, without doubt because it is the basic radical of human existence.

Theology, on the one hand, and deep psychology on the other, move around in a common terrain: deep human worries. Nevertheless and in spite of their commonality and of the help they can render one each other for research purposes they should not be confused. Psychopathological phenomena are not religious, nor the religious ones metaphors of mental illness. Religiosity always implies a transcendence of individuality and some forms of truth and freedom that can only be established apart from an interpersonal relationship. Mental disorder, on the contrary, always implies a difficulty in communicating, a predominance of one’s own world at the expense of a personal relationship. From this perspective, pastoral and medical help and even more the help of the psychotherapist have something in common, which is to give sense to the life of an individual, to establish ways of communication and to help the patient recover that relationship. But, insisting that religiosity remains a symptom of mental disorder is an attitude as archaic as the one that tried to explain mental illnesses as punishments of one or another divinity.

3.1.11 RELIGION AND SPECIFIC MENTAL DISORDERS

Sociocultural influences, including religion, have been designed to play a significant role in the aetiopathogenesis, course, treatment and prevention of some mental disorders, but the literature on religion is very scarce. We will follow the relationship between some specific disorders and religious matters.

3.1.11.1 Eating disorders

Examples of self-starvation are present in the Hellenistic era, although religion and eating disorders have been connected, most notably through descriptions of fasting saints, who expressed their spirituality through an extreme control of their bodies, including abstinence from food. ‘Holy anorexics’ [68] abused their bodies, rejected marriage and sought religious asylum where many perished and became saints. This has been described as ‘spiritual starvation’.

One of the best examples is the case of the saint known as Wilgefortis, Uncumber (in England), Kümmerinis (Germanic lands), Liberata (in Italy and France) and Librada (in Spain). The cult of this saint became very popular in the fifteenth century, and was based on an old legend dating from the eighth or ninth century. The legend takes place in North Portugal and there are several versions of it. Essentially Librada was a Christian adolescent, one of nine sisters sometimes said to have been born from the same delivery. Her father, a noble Roman had promised her to an Islamic king, something that she refused. Other versions tell about the pagan king’s intentions to rape her. The young girl decided to suppress the feminine forms of her body by fasting, in order not to sexually attract men. She was extremely successful because not only did she lose weight and shape, but hair grew
all over her body. The name Wilgefortis has been considered a contraction of the Latin *virgo fortis*, the strong virgin, though here the legend merges with another one, the Volto Santo of Lucca figure of Christ on the Cross, represented bearded and dressed in a full-length tunic like a woman, which lead to consider the figure as a representation of a woman. That is why the name Wilgefortis is also considered as deriving from the Old German ‘heilige Vartez’ (‘holy face’), a translation of the Italian ‘Volto Santo’. The name Liberata or Librada, is due to the fact that God was so impressed with her behavior that He decided to liberate her from her last female attribute, her menstrual periods. From then on, she became the patron of suffering spouses who wanted to be liberated (‘disencumbered’) from their abusive husbands.

From the twelfth to the seventeenth centuries, the number of female saints increased dramatically. The Catholic Church recognizes 261 holy women as saints, blessed, venerable or servants of God. Many of these women lived extremely ascetic lives. Asceticism was the way for those women to attain perfection spiritually through complete self-discipline, which resulted in independence from physical needs. Renunciation of the body symbolized the life-aim of ascetics in the Church, the *Imitatio Christi*: suffering like the Christ [70].

One such saint, Catherine of Siena, led a life of extraordinary asceticism. Catherine abused herself from a young age through self-flagellation. However, the most prominent feature of her asceticism was her self-starvation. Catherine took a vow of virginity in her youth, began her fasting at home, and later moved to a monastery where she became a nun. Catherine regarded her inability to eat both as a punishment from God for her sins, and the means for their expiation. Although her body was emaciated, Catherine frequently displayed the hyperactivity that is commonly experienced by anorexics.

Clinicians have noticed the ascetic aspects of adolescents since Anna Freud. Self-discipline and denial is an important adaptive resource to defend against hedonistic tendencies, but also to establish mastery over life. Then the practice of strict self-denial is considered as a measure of personal and spiritual discipline, but on the contrary, other authors considered that ascetism may be used as a justification for continuing an eating disorder [71].

Ascetism and intellectualization are the two basic defence mechanisms present in anorexia nervosa. Intellectualization leads to a life style contrasting with the traditional role of the Neolithic mother and housewife. The poet Octavio Paz [72] wrote a beautiful biography of Sor Juana Inés de la Cruz, a Spanish poet living in Mexico during the seventeenth century. She described her as a highly gifted adolescent who enjoyed participating in cultural gatherings at the Mexican salons with aristocrats, artists and high rank priests. Her religious clothes protected her from men’s assails and permitted her to be present at such get-together parties.

A study which compared 34 anorexics and two control groups of non-organically ill, non-psychotic female psychiatric patients found that two MMPI items discriminated between the groups [73]. The anorexics responded significantly more frequently in the affirmative to the items ‘I read in the Bible several times each week’, and ‘I pray several times every day’. The authors did not speculate about these interesting findings in their discussion of the results. As there is currently limited information on the prevalence of eating disorders among religious subcultures as well as meanings attributed to anorexia by anorexics, it remains an open area of potentially important research.

Other authors have found a positive relationship between eating disorders and religion, with eating disorders being most prevalent among Catholics and Jews [74]. One aspect of
religion, that has protracted anxiety in individuals with eating concerns, is religious activities involving food. Some patients had altered religious practices including avoidance of Holy Communion, resulting in patients feeling extremely guilty [75]. A more recent study [76] found that women who are involved in religion for extrinsic reasons (for personal and social gains and acceptance) tend to be more susceptible to bulimia.

The fact that the explanatory model of anorexia fails to recognize sufficiently the ‘culture-bound’ and moral aspects of the syndrome implies that potentially important patterns have become irrelevant in the diagnosis process and in the management and treatment of the patients. It must be recognized that there are complex interactions among religious faith and the pathogenesis of anorexia nervosa which can be very relevant for the clinical management of patients. In some of the cases, religious beliefs provide a containment of maladaptive behaviors, through prayer and through a sense of belonging to the religious community. In other cases, the relationship is more profound and it may be difficult to separate the concept of a punitive God from the illness process [77].

There has always been a strong association between eating or refraining to do so and moral values. Mass media, in particular advertisements and the internet, commonly use religious and moralistic themes in connection with eating and in promoting modern-day ‘nutritional’ consumerism and fundamentalism (diet, discipline and discipleship) by using words such as ‘temptation’, ‘decadent’, ‘heaven’ and ‘purity’ [78].

Currently, patients with anorexia nervosa frequently become chronic with multiple relapses and there is as yet no effective treatment. Cultural factors are not yet understood and may play an important role in the ethiopathogenesis of this disorder.

### 3.1.11.2 Affective disorders

Religion’s relationship to mental health has historically been questioned as though it were either positive or negative [12, 41, 60]. Now it seems clear that the more appropriate question is which aspects of religious functioning have positive or negative relationships with aspects of mental health.

Some studies have found that religious people are less likely to divorce, use less alcohol and drugs, have more access to social support, experience less depression and anxiety, and are less likely to commit suicide.

If religious beliefs and practices improve coping, reduce stress, prevent or facilitate the resolution of depression, improve social support, promote healthy behaviors, and prevent alcohol and drug abuse, then a plausible mechanism exists by which physical health may be affected [79]. Positive religious coping strategies include searching for spiritual purification, looking for a new religious direction, providing spiritual support for others, whereas negative religious coping strategies include feeling dissatisfied, attributing the stressor to the devil, interpersonal conflicts, religious doubts, or perceived failures of faith, guilt associated with failures of virtue, fears and condemnation [80].

The relationship between spirituality and mental illness has been less consistent, with some studies showing decreased odds of mental illness and depressions [81].

A large sample found that people considering themselves as spiritual were less likely to have attempted suicide, and among the general population religious attendance of at least once per year is associated with decreased suicide attempts, and this relationship persists even after the influence of social support is removed [82].
3.1.11.3 Posttraumatic stress disorder

Contemporary approaches to trauma research have further broadened conceptualizations of outcome by identifying perceived benefits such as positive changes in self-perception and relationships with others. The identification of factors that may contribute to resilience or positive functioning should be taken into consideration in trauma research.

One area of functioning that has been implicated as both a means of coping and outcome of traumatic events is religious functioning. The September 11, 2001 terrorist attack triggered a widespread increase in attendance in religious services and practices. This disaster reaction has to be considered as a coping behavior different from other clinical responses [83].

A recent study found a positive relationship between religious functioning, posttraumatic growth and PTSD symptoms, and that may be useful for them to consider referrals to pastoral counselling [84].

3.1.11.4 Obsessive-compulsive disorder and scrupulosity

Cultural factors may influence the nature of obsessions and compulsions associated with the obsessive compulsive disorder (OCD). In fact, a variety of symptoms related to religious thoughts are more prevalent in clinical populations from countries in which religion is at the central core of the society, particularly in Muslim and Jewish Middle Eastern cultures, as compared with clinical populations from the West.

The current historical record suggests that Bishop John Moore of Norwich in 1691 delivered the first public address on the topic of scrupulosity, which he referred to as ‘religious melancholy.’ He describes the effect of the disorder on the individual: ‘a flatness in their minds . . . which makes them fear, that what they do, is so defective and unfit to be presented unto God, that he will not accept it. . . . They experience naughty, and sometimes Blasphemous Thoughts which start in their Minds, while they are exercised in the Worship of God . . . despite all their endeavours to stifle and suppress them . . . The more they struggle with them, the more they increase . . . They are mostly good People . . . for bad men . . . rarely know anything of these kinds of Thoughts’ [85]. Scrupulosity has been described as a psychological disorder primarily characterized by pathological guilt or obsession associated with moral or religious issues that is often accompanied by compulsive moral or religious observance and is highly distressing and maladaptive.’. Scrupulosity has been defined as a set of ‘persistent doubts about sin and irresistible urges to perform excessive religious behaviour’ [86]. It has been described that between 10–30% of OCD patients experience religious obsessions [87], and 5% of OCD patients experience religious obsessions as their primary type of obsession [88]. Assuming that just the 5% of OCD patients with primarily religious obsessions represent scrupulosity, the prevalence of scrupulosity could be considerable, including up to approximately 100 000 people in the United States alone.

Scrupulosity patients may become so overwhelmed with moral and religious concerns that they are actually incapable of fully processing all of their thoughts, which contributes to poor awareness [89].

Scrupulosity patients may not be aware of the content or underlying causes related to their disorders, leading some authors to consider that it is an anxiety disorder [90].
Many scrupulosity patients engage in compulsive confession and restitution-seeking, which often arouses attention from religious authorities and subsequent religious counseling or clinical treatment. Compulsive confession to religious leaders is viewed as a mechanism to resolve feelings of guilt and restore one’s relationship with God and is often apparently pathological in terms of frequency and quality.

Patients may withdraw from social and religious communities as a result of dissatisfaction and anxiety, which may further aggravate the condition by depriving patients of reality testing and social support. In response to feelings of meaninglessness, some patients seem to construct their entire existence around the meaning of sin and punishment in an unsuccessful attempt to create a driving purpose for existence. Conversely, purposelessness may lead scrupulosity patients to continuously ruminate about the possibility that life has no inherent meaning, which could constitute a causal component of the pathological doubt and questioning that pervades the lives of scrupulosity patients.

3.1.11.5 Substance use and drunkenness

Man may have been producing alcoholic beverages since the Neolithic Revolution, 10,000 BC. Agriculture started with cereal grasses such as emmer wheat, einkorn wheat and barley which are not those plants with larger seeds which would turn out greater caloric foods. Small cereal seeds are suitable for the production of beer. In any case there are records dating back to 6000 BC of beer production which is recorded in Ancient Egypt and Mesopotamia. The inventions of bread and beer have been parallel and are considered to be responsible for the birth of technology and the founding of civilization.

Every culture imposes strong pressure against the use of substances leading to intoxication or controls their use in specific places, at specified time periods during religious ceremonies. The Eleusian Mysteries in Ancient Greece are one of the best known examples of this kind. Twice a year people from all over Greece gathered for several days for ceremonies which had the aim ‘to elevate man above the human sphere into the divine and to assure his redemption by making him a god and so conferring immortality upon him.’ [91] The ceremonies centered on the cult of the goddess Demeter, the one who taught the secrets of agriculture to man. Some scholars believe that the power of the Eleusinian Mysteries came from a beverage consumed at certain moments of the rituals called kykeon. Kykeon was made out of barley and a sort of mint, pennyroyal. Barley can be parasitized by ergot, which contains psychomimetic alkaloids. For other scholars, Ancient Greeks knew how to produce other psychoactive substances.

Some religions, particularly Islam, prohibits alcohol consumption altogether. Many others permit the consumption of alcohol but condemn intoxication because it is considered to be a constraint to free will or an action of devils, as expressed in the Bible: ‘Ye are the children of light, and the children of the day: we are not of the night, nor of darkness . . . they that be drunken are drunken in the night. But let us, who are of the day, be sober . . . Abstain from all appearance of evil.’ (1 Thessalonians 5:5, 7–8, 22).

Drunkenness or inebriation is the consequence of intoxication with alcoholic beverages and, by extension, by other substances, leading to an impairment of mental and physical faculties. The drunken person behavior is noticeable for the slurred speech, ataxia, poor co-ordination, reduced inhibition, by being clingy to others, invading their personal space and interfering with their behavior. The flushed face, the smell of alcohol and the reddened
eyes distort the appearance of the drunken person. Drunkenness is accompanied by a wide range of emotions such as anger, sadness, euphoria, light heartedness, joviality, and sexual disinhibition. In short drunkenness is a behavior characterized by a loss of normal rational behavior patterns.

There are several Bible passages dealing with alcohol and its evil effects in spite of the fact that potent distilled beverages were then unknown. The first and most quoted is the episode of Noah producing wine which he drank and became intoxicated. This causes him to disgrace himself in front of his family and lead to family strife (Genesis 9:20–27). In the Old Testament, drunkenness was considered worthy of death (Deuteronomy 21:20–21). In Christian theology drunkenness has often been considered to be a sin, even a major one. The New Testament says that those who indulge in strong drink will not inherit the Kingdom (Luke 12: 45–46; 1 Corinthians 6: 9–11; Galatians 5: 19, 21), although wine in itself is not considered an evil; it is the drinking of it in excess (1 Peter 4:3) that displeases God. Jesus himself attended a marriage feast in which wine was being served. It was there that he performed his first miracle: that of changing water into wine (John Chapter 2).

Even nowadays there are strong cultural and religious differences in the attitudes towards alcohol. Jewish culturally supported beliefs may discourage drinking and drunkenness as ways of socializing and coping with stress. Thus Jewish men under stress may be relatively more likely to become depressed, and less likely to use and abuse alcohol [92]. Compared to Protestants Jews have less favorable beliefs about alcohol and drink less [93].

Students with no religious affiliation report significantly higher levels of drinking frequency and quantity, getting drunk, celebratory reasons for drinking and perceived drinking norms than those of either Catholic or Protestant religious affiliation. Protestants reported significantly higher levels of perceived drinking control than Catholics [94].

A study in the Western Isles of Scotland reported slight differences between Protestants and Catholics in drinking behavior patterns. Protestants were more likely to endorse an abstinent position, while Catholics were more permissive in their attitudes towards drinking [95].

### 3.1.11.6 Schizophrenia

Data on phenomenology of delusions, hallucinations or Schneider’s first rank symptoms in schizophrenics demonstrate a remarkable influence of culture on the content of psychotic symptoms. In German psychiatry, Zutt [55] established the term pathoplasticity to describe the culture-sensitive aspect of the manifestations of mental disorders.

Schizophrenia religious delusions were described in different cultures and in different times. The term religious delusions includes acute and chronic ideas of being damned by God, or being God.

Spirituality and religiousness have been shown to be highly prevalent among patients with schizophrenia; however clinicians are rarely aware of the importance of religion for a patient. Spirituality and religiousness should be integrated into the psychosocial dimension of schizophrenia. Religion can help in reducing anxiety, depression and negative symptoms, and can provide guidelines for interpersonal behavior. In almost two thirds of patients (71%) religion was a positive way of coping and in 14% had a negative effect [96]. Nevertheless there does not seem to be any relationship between religious delusions and personal religiosity [97].
The relationship between spirituality and adherence to treatment has been studied among patients with severe chronic physical disorders, cancer, and terminal diseases. In some studies it has been proved that being religious increases patients’ satisfaction and adherence to treatment. In people with schizophrenia it improves quality of life, better social support, and more positive representations of the illness and may aid recovery by instilling hope, purpose and meaning of life [98].

There are few studies that have examined how religious affiliation affects delusional thinking [99] but the amount of religious activity prior to psychiatric hospitalization was a strong predictor of the severity of religious delusions currently experience independent of religious affiliation [100].

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