Experience comprises both cognitive and affective elements. The cognitive emphasis to date has ignored the important role of emotional factors in maintaining belief. R. Firth (3) conceptualized religious belief as a set of ideas more or less integrated by reason but held with conviction that they are true – that they are meaningful in relation to reality. He points out that we can distinguish elements of knowledge, emotion, and volitional activity acting on belief. It is the element of emotion in whatever kind of experience that gives a basis to belief and provides it with a strong flavour of reality.

While I would accord with Pargament and Lomax's (who themselves quote the anthropologist C. Geertz) assertion that religion provides a source of meaning for believers, social anthropology moves beyond individual beliefs and provides a broader perspective through looking at the ways in which power structures and religious hierarchies engender specific convictions and the ways that these convictions are contested by different factions in communities.

Anthropologists have long recognized the importance of specific religious experiences in maintaining wellbeing in communities and the role of rituals in engendering such experiences. There is wealth of anthropological data examining the role of rituals in engendering mental health. Yet the existing scholarly work has not examined the mental health implications of specific rituals. For instance, despite the fact that much of the contemporary

literature has focused on Christianity, there is a dearth of work examining Christian rituals such as Baptism, the Eucharist, and laying on of hands in terms of facilitating wellbeing. Religious experience and rituals and their impact on wellbeing should be a future target of research in this area (4).

Furthermore, long-term immersion in a religious community facilitates the collection of detailed phenomenological descriptions of religious experiences, such as hearing God's voice, and allows an understanding of how they are interpreted in diverse cultural contexts (5). It allows to better understand the similarities and differences between normative religious experience and psychopathologic states.

One area that Pargament and Lomax discuss – religious hallucinations – has attracted some anthropological discussion. Anthropologist T. Luhrmann (6) points out that hallucinations are a vivid illustration of the way culture affects our most fundamental mental experience and the way that mind is shaped by both cultural invitation and biologic constraint.

The anthropological literature has indicated that conceptualizations of wellbeing include physical, emotional and spiritual dimensions, and similarly healing often reflects the reestablishment of a harmonious relationship with whatever communities label as the transcendent through diverse rituals. As the social anthropologist V. Turner points out in his work among the Ndembu (7), healing does as much to repair the social fabric as it does to repair the body, mind, and soul of suf-

ferers. Thus, the impact of religion/spirituality on mental health should encompass measures of social harmony and social integration.

Finally, in terms of treatment, there is by now a growing literature on cross-cultural psychotherapy and the benefits of matching patient and therapist (8). This literature demonstrates that, while sometimes cultural matching enhances psychotherapeutic efficacy, other factors such as gender and social class are equally important in determining outcomes. These findings could be extended to research on spiritually integrated therapy, looking at the ways in which religious matching may enhance or diminish outcomes.

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Spiritual assessment as part of routine psychiatric evaluation: problems and implications

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Pargament and Lomax provide a comprehensive and clear review of the way religion may impact on symptoms and outcome in patients with mental disorders, both in its positive and negative aspects. Their work is predomi-

nantly based on the important research conducted by Pargament and colleagues on religious and “meaning-making” coping. They propose that many patients use religion both as a coping resource and as an explanatory model for their

disorder (1). This can have positive consequences (e.g., “I think my illness is God’s punishment for my sins. It gives meaning to what happened to me, so it is less unjust”) or negative ones (e.g., “I have been praying for years. I am still ill because I don’t believe in God’s healing power enough. I am a bad person”) (2).

Negative aspects of religion can be expressed through “religious struggle”, a complex concept for many clinicians. Spiritual struggle can be intrapersonal, interpersonal, and/or related to the patient’s representation of God. The fact that religious struggle may be the cause or the consequence of psychopathology (or both) has to be considered while assessing this phenomenon.

Pargament and Lomax’s paper should help clinicians to disentangle the various ways in which religion can be used: as a resource for coping with the illness, as a source of emotional comfort (e.g., to relieve anxiety) or meaning, and as a means of self-regulation and better social functioning. Clinicians should possess some familiarity with these concepts before performing spiritual assessment, which should be part of routine psychiatric evaluation (3). However, they will discover that more than one of the above aspects are often present in any given patient at a given time (3). For instance, a patient with schizophrenia may produce delusions with religious content (“The devil speaks to me . . .”) while at the same time being capable to relieve his/her anxiety by praying to God. It is important to be aware that screening questions can be used in a thorough assessment of all aspects of a patient’s religiosity (3,4).

After the spiritual assessment has been completed, how should we then proceed? The issues that arise should be addressed first of all as part of supportive psychotherapy, by fostering positive coping and dealing with its negative forms (e.g., spiritual struggle). In some cases, however, issues may become more complex, depending on the cultural context in which treatment

is provided. In some areas where there are no psychiatrists, traditional healers will try to help patients with mental disorders in the context of “integrated care” involving both spiritual healing and more secular techniques (with more or less success). Conversely, in most European countries, psychiatrists work from a layman’s position. Hence, issues arising from spiritual assessment may be considered as pertaining to chaplains and/or religious representatives. Half-way between these two positions, there are places where matters are intertwined. In the United States, for example, some clinicians may pray with their patients, a position which would not be considered as acceptable in most public psychiatric facilities in Europe.

The complexity of this field is also related to the existence of a “gray zone”, sometimes grounded in the domain of psychotherapy, where some intrapsychic material may be considered either as “theological” or as a cognitive process warranting psychological intervention or as both of the above (for instance, the guilt a woman feels following abortion, which is partially grounded in religious considerations).

So what should we do? On the one hand, psychiatrists should adapt their practice to what society asks of them. On the other hand, there are contexts in which “local care” is inconsistent with effective conventional treatments (such as antipsychotics for psychotic symptoms). In some areas, patients first consult their local practitioner and then turn to more traditional medicine when they figure out that the former does not bring improvement (5). In these situations, clinicians should better not compete with these approaches but find ways of applying different models in a complementary fashion (6). This may be frustrating when considering the time – and money – that is likely to be lost in this sequence of steps. However, there is actually no other choice: people embedded in a culture involving religious explanatory models for their

disorders will frequently look for traditional care before trying more conventional psychiatry. The role of psychiatrists is to take the cultural context of their patients into account, which may involve building a collaborative relationship with members of religious communities when necessary.

In conclusion, we would like to emphasize that: a) spiritual assessment should be part of the investigation of the cultural context of any patient consulting in a psychiatric facility, according to WPA recommendations (7); b) spiritual assessment is likely to reveal psychological and social issues that are relevant to treatment; and c) these issues may have psychotherapeutic, psychiatric, and social implications, depending on the patient’s characteristics and the local psychiatric and cultural context.

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