Positive psychology and the provision of religiously-sensitive mental health support services to cultural minority groups in the UK.

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Aims

- To mention UK initiatives concerned with incorporating spiritual and religious concerns into mental health care in a religiously and culturally diverse society.
- Religious-cultural diversity – problems with mental health care:
  - Stigma
  - Anonymity and confidentiality issues
  - Examining negative states and feelings
  - Does one size fit all? Fear of misunderstanding
- Religious-cultural diversity – solutions
- Positive psychology
  - What is it?
  - Is it effective?
  - Specific examples of its use

Salience of religion among minority ethnic groups in the UK

Some UK initiatives concerned with incorporating spiritual and religious concerns into mental health care in multicultural settings – deal with professional and academic issues, research, training, conferences and events.

- National Spirituality and Mental Health Forum,
- Spirituality Special Interest Group of the Royal College of Psychiatrists,
- Association for Pastoral and Spiritual Care and Counselling,
- British Association for the Study of Spirituality,
- Mental Health, Religion and Culture,
- University of East London Certificate in Spiritual, Religious and Cultural Care.

Religious-cultural diversity – problems with mental health care

Psychological help/treatment for psychological disorders are seen as threatening, and mental health problems as stigmatising (sources: Cinnirella & Loewenthal, 1999; Lindsey et al, 2003; Loewenthal & Brooke-Rogers, 2004; Frosh et al, 2005)

"*The one thing Black people hate is for anybody to find out there is any form of mental illness in their families…what they try to do is shut that person away and deal with it by themselves as opposed to going through all the networks and being exposed."(*Black Christian)

"*If people can identify you as someone being depressed, I think it's going to make it worse because in a way they tend to be rejected". (*South Asian Muslim*)*

"*Our people do not go to the doctor (when depressed), in fact they hide it, because they think that if people know about it they will not accept them and they'll be laughed at and would be completely shut off because there is this prejudice*"(South Asian Muslim)

"*I have to call myself a counsellor, not a psychotherapist, otherwise no-one would dare to consult me "(*Orthodox Jewish*)*

(re a service helping mothers who have just given birth) "*I wonder what type of families need this? Is it just those who can't cope? I might feel ashamed to ask for such help"*

Fear of misunderstanding

- Al -Krenawi & Graham (2000), Loewenthal (2009) potential Muslim and orthodox Jewish patients may not wish to seek help because they fear their observing religious rules will be misinterpreted e.g. “They thought my husband was sick because he wouldn’t shake hands with a woman (psychiatrist)” (Orthodox Jewish woman)
- We wanted to have a bible study group on the (psychiatric) ward but they wouldn’t let us. They thought religion would make us worse (Black Christian woman).

Ways of overcoming barriers to treatment in religious-cultural minority groups

- Cultural-religious awareness training. Improving feelings of being understood by professionals from other groups.
- Training members of cultural-religious groups as mental health professionals – how well do these training schemes work? How well are trainees accepted?
- Culturally-religiously appropriate therapy
- Reduce stigma – e.g.
  - More information in religious groups about mental disorder, its forms and treatments
  - More openness from those affected and their families
  - Groups where roles of members are not disclosed
- Reduce anti-psychiatry/psychology attitudes among religious leaders.
- Reducing other barriers eg. religious objections to aspects of psychiatric/psychological treatment.
- Positive psychology

What is positive psychology?

- Seligman (*Authentic Happiness,* 2002) has defined agendas for research and clinical work in positive psychology. Traditional psychological research and clinical work have focussed too heavily on *pathology* and *negative* emotions.
- *Positive* feelings, and behaviours that engender *authentic happiness*, need more attention. The exercise of *signature strengths* engender happiness. Signature strengths include:
  - Honesty
  - Kindness
  - Spirituality
  - Forgiveness
  - Hope
  - Gratitude
  - Purpose

and other qualities endorsed and fostered by religious systems.

It would be useful to know

A. whether these qualities are (empirically) present more strongly among the religiously active;

B. whether the exercise of these qualities improves wellbeing;

C. whether the religiously-active/members of minority groups prefer a focus on positive states.

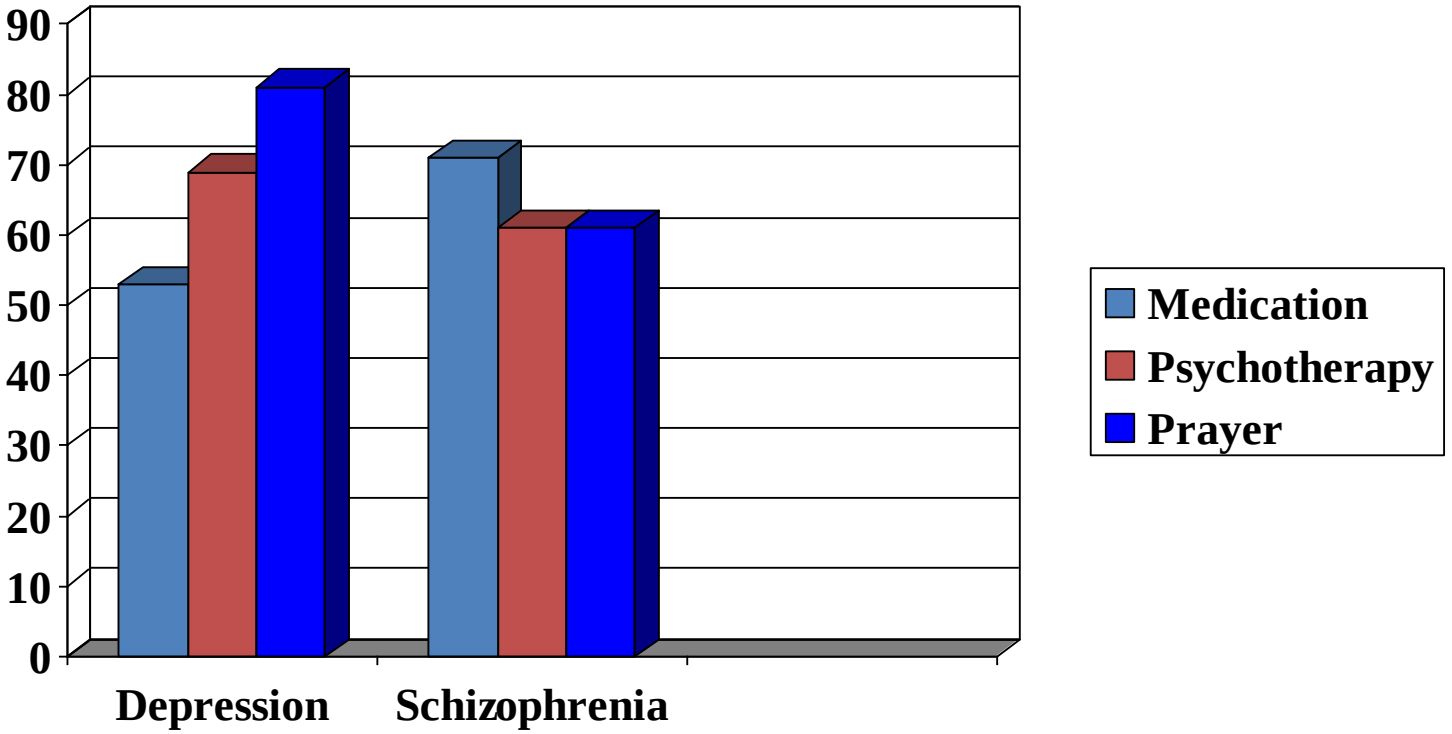
Purpose in Life

- Paloutzian (1981) suggested that religious activity is associated with raised purpose in life (e.g Paloutzian, Richardson & Rambo, 1999; Koenig, 2001; Ng & Shek, 2001).
- Ardelt (2003) suggested that the relations between religion and wellbeing was the result of purpose in life
- In general, ideas from religious study are likely to contribute to the beliefs that contribute to purpose in life and other positive emotional states e.g. Francis (2000) bible reading contributed to purpose in life.

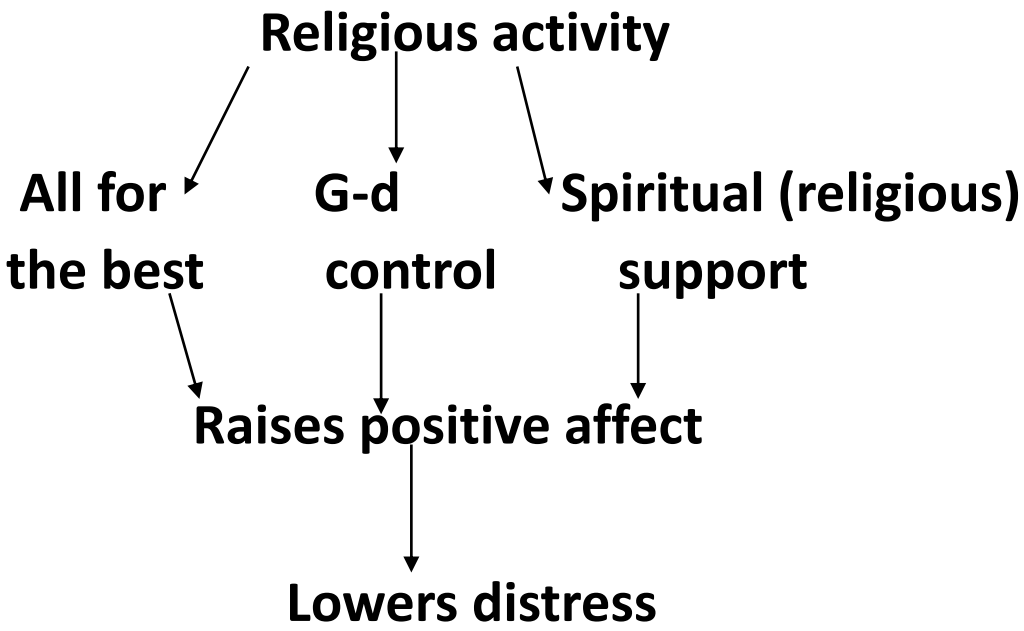
Spirituality:

Religion is normally associated with greater happiness (e.g. Lewis & Cruise, 2006).

Prayer compared with other forms of help for mental illness in terms of its perceived effectiveness e.g: proportion of people (from Black and White Christian backgrounds, Hindus, Jews and Muslims) endorsing the helpfulness of medication, psychotherapy, and prayer. (Source: Loewenthal & Cinnirella, 1999)



Very little attention has been given to positive mood in the enormous literature on religion and distress. In our study of UK Protestants and Jews, religious activity affected positive mood, and had only an indirect effect on negative mood (Loewenthal, MacLeod, Goldblatt, Lubitsh & Valentine , 2000, 2009):



Spiritual growth and meaning

Accounts of dealing with mental and physical illness and suffering mention spiritual growth, also hope, gratitude and forgiveness – themes also appearing in the positive psychology literature (Seligman, 2002; Watts et al, 2006).

- Crabtree (2005) described patients in a Malaysian psychiatric hospital trying to seek spiritual unity, in efforts to regain equilibrium:
  - Foo, a devout Buddhist, spent much time reading as well as practicing meditation; energy devoted to spiritual development was seen as essential in the progress to recovery.
  - Edward, a fervent Christian, saw his compulsory admission as a personal test of worth, as well as a time in retreat, much as a monk might see a time of solitude and testing as sacred.
- Mohamad et al (2011) interviewed Muslim students in Malaysia, they said that having a close relationship with God and serving His purpose helps them to perceive life to be meaningful.
- Leibrich (2002) writes: “Every time I have had an episode of illness in my life, I have been on some kind of spiritual journey by the time it is over…I see myself becoming more and more whole…. There are many ways…through reflecting with gratitude on the things I have…”.

Forgiveness

Among Western Christians, McCullough & Worthington (1999) concluded that relationship between religious involvement and forgiveness is strong, when forgiveness is assessed as a *general* trait. The relationship is weaker, for forgiveness in *specific* situations – for example, when individuals are asked to think of someone who has harmed them in the past, and to assess their current feelings towards that person.

- Not all signature strengths are stressed equally in all religious systems. For example forgiveness and regret for wrongdoing appear to be more strongly emphasised in Christianity and Judaism than in Buddhism and Islam.
- Paz et al (2007) reported that in China, Buddhist participants were slightly (but significantly) more resentful and less forgiving than the Christian participants
- Does forgiveness relate to well-being? It has been reported to be associated with increased hope, higher life satisfaction, lower depression and anxiety, and higher self-esteem and relationship adjustment (McCullough & Worthington).

Using a positive psychology frame in mental health work: Some driving events

Standard psychometric measures of distress and psychopathology are intimidating, and often have culturally inappropriate features. Here are some test items to which we got aversive reactions from minority groups, and could not use.

- **Rosenberg Self-Esteem** (1965)e.g.*"All in all, I am inclined to feel that I am a failure"; "On the whole I am satisfied with myself"; "I feel I do not have much to be proud of".*
- **Negative Affect** (Watson et al, 1988)e.g. self-ratings of *"Distressed", "Upset", "Irritable"*
- **Post Natal Depression** (Edinburgh PND: Cox et al, 1987)*e.g. "Things have been getting on top of me"; "The thought of harming myself has occurred to me"; "I have felt sad and miserable".*

In establishing religiously and culturally appropriate services, potential users objected to activities that focused on negative feelings and behaviours.

Blumental, Herzog & Loewenthal (2006) describe setting up a post-natal depression prevention service under the Sure Start aegis. Three focus groups with potential users discussed post-natal moods, family relationships, factors affecting these, and possible helpful services. Important themes were:

- Support groups were NOT an attractive option: “We don’t want to sit around talking about our feelings”
- One-off sessions and SHORT courses that would enhance parenting and related practical skills were potentially attractive. Sessions offering religious inspiration and enhancing religious coping were also attractive.
- They wish to be empowered, to be offered positive suggestions, spiritual inspiration, skills, and knowledge.

Examples of some popular sessions

- Religious coping – positive thinking
- Time management
- Healthy diet and menu suggestions
- Celebrating religious festivals
- Children's arts and crafts, outings and holiday activities
- Baby massage
- Art therapy with young children
- First aid for babies and young children (delivered by a qualified instructor and leading to a certificate)
- Dealing with children's sleep problems
- Dealing with crying
- Complementary medicine: suggestions for childhood ailments

Practising baby massage

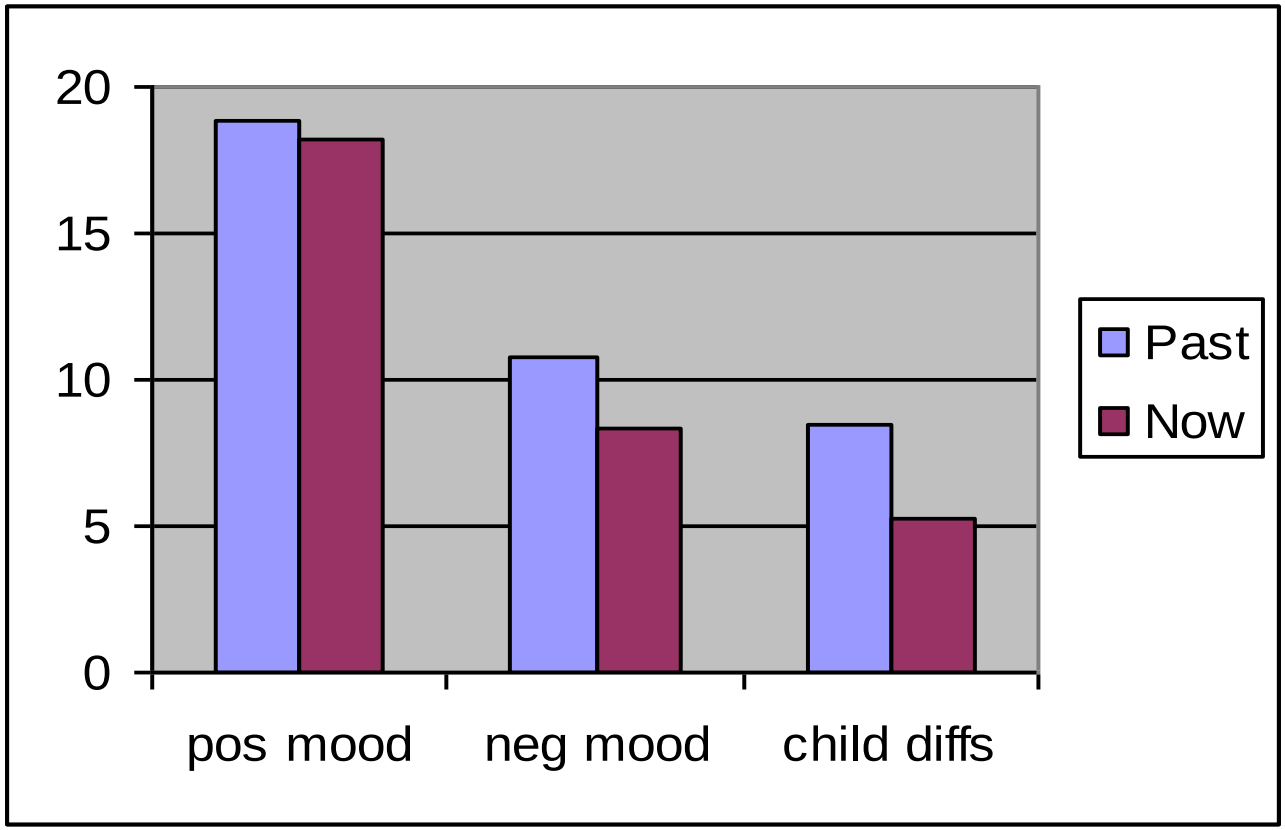
A First Aid instructor demonstrates infant resuscitation

Were these interventions effective?

Reported changes in carer (mother's)mood and children's difficulties following Sure Start use.

Significant drops in carer negative mood and child difficulties.(n=19, pos t=1.2 ns, neg t=6.8 p<.001, child t=3.0 p<.01, df=18)

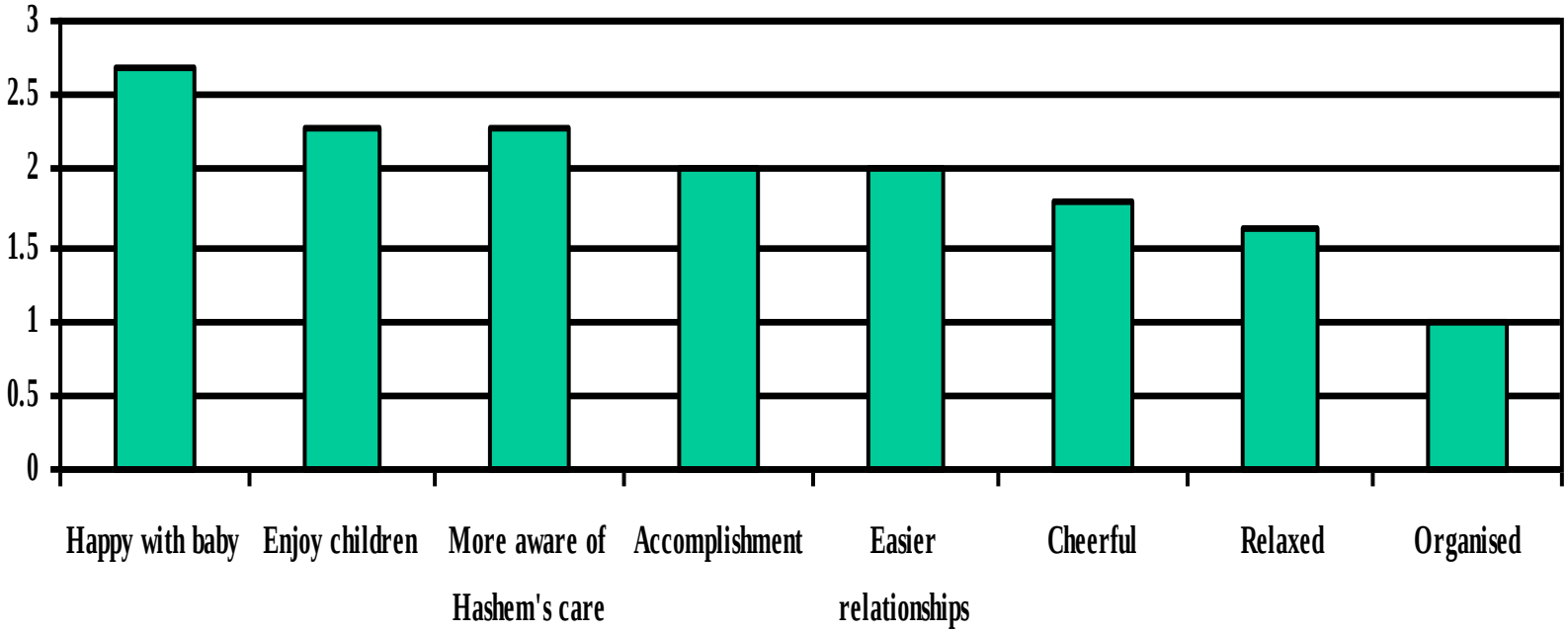
(Heywood & Loewenthal, 2006)



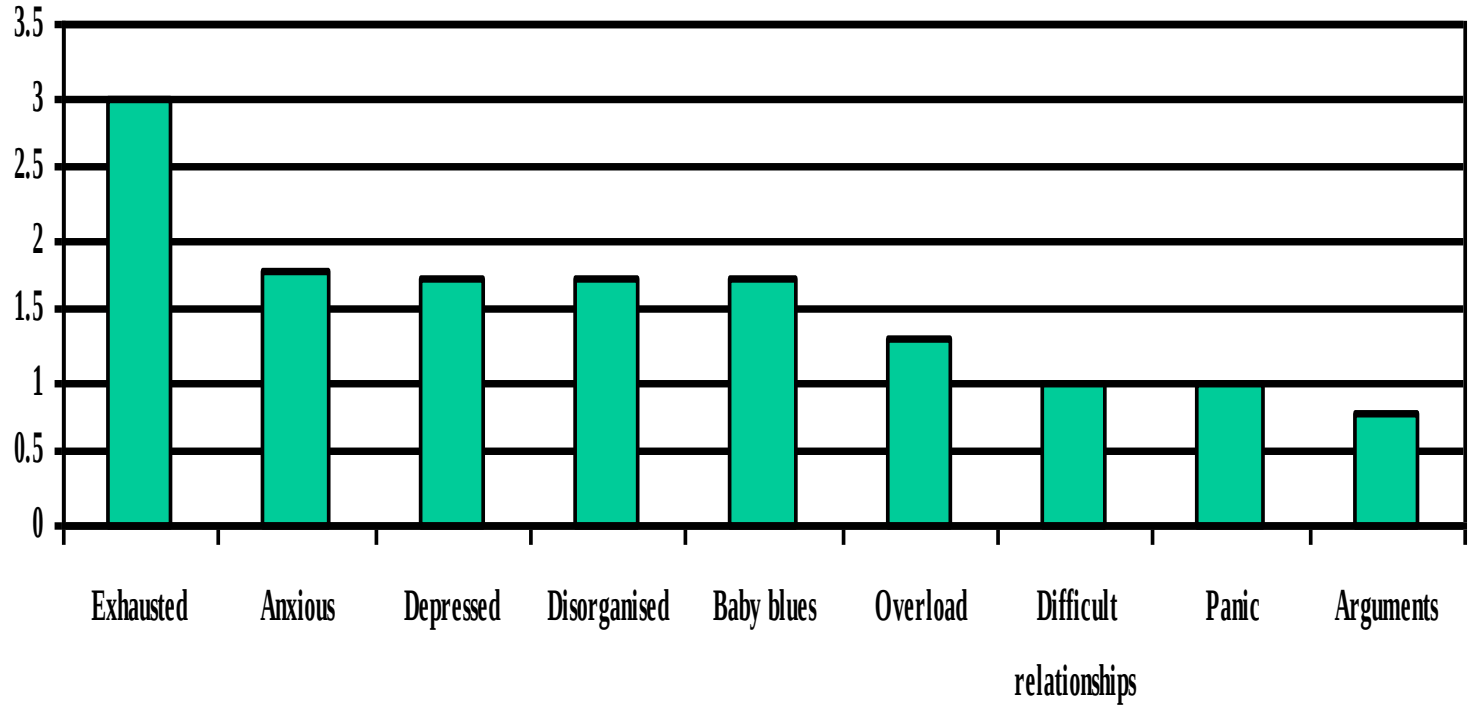
Studies of post-natal mood (Loewenthal, 2006)

- Women (n=20 focus group participants)described a range of moods common in the post-natal period. These did not correspond closely to the moods in standard depression measures. It was considered important to develop a culturally-appropriate measure.
- A pilot study (n=13 session participants, n=15 session participants) evaluated a culturally-appropriate post-natal mood measure.
- Positive states were more often experienced than negative states
- The most strongly experienced negative mood was ***exhaustion.***
- Positive moods, generally experienced more strongly than negative moods, included ***enjoyment of the baby, better family relationships, and enhanced spirituality***.

Positive feelings experienced in the year after childbirth



Negative feelings experienced in the year after childbirth



- N Loewenthal (2011) introduces Jewish mystical ideas to enhance the work of psychotherapists (often but not always working with Jewish clients).
- For example: using concepts relating to the idea of an “inner sanctuary”. A client with a difficult interpersonal relationship wrote: “When I imagine the sanctuary inside my chest it is a reminder of the presence of a spark of G-dliness inside me (or any other human). The first reaction when I have this image is a flash of joy. The second reaction is relaxation and peace...in difficult situations (relationships), when I usually lose myself, (then) imagining the Temple with the Holy of Holies, and trying to stay around the inner court, helps me not to lose myself...to feel safe and protected.

Conclusions

The concepts, measures and methods of positive psychology may be more readily acceptable among religious/minority groups, than the traditional methods employed for investigating and managing undesirable feelings and behaviour.

Use of services may be increased.

It is possible that enhancing positive mood reduces negative states, reducing the need for work focussed on negative states.

More work needed of effectiveness.