THE IMPACT OF PERSONAL RELIGIOSITY AND CULTURE
ON THE CONTENT OF DELUSIONS AND HALLUCINATIONS
IN SCHIZOPHRENIA

Doctoral Dissertation

Biomedical Sciences, Medicine 07B

Kaunas, 2008
Dissertation prepared at Vilnius Mental Health Center during 2004–2008

Dissertation will be defended extramurally

Scientific consultants:

  Dr. Habil. Robertas Bunevičius (Kaunas University of Medicine, Biomedical Sciences, Medicine-07B)
  Prof. Dr. Thomas Stompe (Vienna University of Medicine Vienna, Biomedical Sciences, Medicine-07B)

The dissertation will be defended in the Medical Research Council of Kaunas University of Medicine

Chairman

  Dr. Virginija Adomaitienė (Kaunas University of Medicine, Biomedical Sciences, Medicine – 07B)

Members

  Prof. Dr. Habil. Jolanta-Justina Vaškelytė (Kaunas University of Medicine, Biomedical Sciences, Medicine – 07B)
  Dr. Habil. Donatas Stakišaitis (Mykolas Romeris University, Biomedical Sciences, Medicine – 07B)
  Prof. Dr. Habil. Limas Kupčinskas (Kaunas University of Medicine, Biomedical Sciences, Medicine – 07B)
  Prof. Dr. Kazimieras Meilius (Mykolas Romeris University, Social Sciences, Law – 01S)

Oponents

  Assoc. Prof. Dr. Zita Vincenta Liubarskiênë (Kaunas University of Medicine, Biomedical Sciences, Public Health – 10B)
  Prof. Dr. Kamaldeep Bhui (London Medical University, London, United Kingdom, Biomedical Sciences, Medicine – 07B)

Dissertation will be defended in the public session of the Medical Research Council of Kaunas University of Medicine in the Sympozium Hall of the Teaching Laboratory Building at 2 p.m. on the 3rd of September, 2008

  Address: Eivenių str. 4, LT – 50009, Kaunas.

Dissertation summary was mailed out on the 3rd of August 2008.

This dissertation is available at the Library of Kaunas University of Medicine.

  Address: Eivenių str. 6, LT-50161 Kaunas
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LIST OF ABBREVIATIONS

A.D.          Anno Domini (A.D. is an abbreviation of the Latin phrase anno domini, meaning “in the year of our Lord”)
APSA         American Psychiatric Association
CI            Confidence Interval
CPD           Continuing Professional Development
DSM-IV       Diagnostic and Statistical Manual of Mental Disorders Fourth Edition
FPS           Fragebogen für Psychotische Symptome
FRS           First Rank Symptom
ICD-10       International Statistical Classification of Diseases and Related Health Problems, 10th edition
IPSP         International Study of Psychotic Symptoms
OR            Odds Ratio
PCA          Principal Component Analysis
Ru            Rudaleviciene
SCI          Structured Clinical Interview
SD            Standart Deviation
Sto          Stompe
UK            United Kingdom
USA           United States of America
WACP         World Association of Cultural Psychiatry
WHO          World Health Organization
WPA          World Psychiatric Association
WPA-TPS      World Psychiatric Association, Transcultural Psychiatry Section
1. INTRODUCTION

1.1. Relevance of the research of schizophrenia

Schizophrenia has always been the top interest in Psychiatry and its main challenge, and is still left with the most number of unanswered questions, and it is the ongoing modern topic. There is still a considerable controversy - whether it is a disease, a syndrome or just a reaction? Without going into the pros and cons of the controversy and merits of different scientific groups justifying their standpoint by emphasizing “progressive deterioration“ [Kraepelin, 1904], ”disturbances of various psychological processes“ [Bleuler, 1924], or “characteristic symptomatology“ [Schneider, 1959], and the changes now effected in the final outcome by modern methods of treatment, it stands to reason to believe that “Schizophrenia comprises a group of psychotic disorders having multifactorial etiology and presenting in most cases as a severe psychotic breakdown. “Among all major psychiatric disorders, schizophrenia has been of the greatest concern to clinicians and scholars since the very beginning of the history of the mankind because it is one of the most severe and prevalent mental disorders of the humankind [Tseng, 2001]. Although most scholars now view schizophrenia as predominantly attributed to biological factors including heredity), past attempts to investigate the disorder from social and cultural perspectives have made certain contributions that deserve to be taken to account considering the illness. Since psychiatric disorders are a human process, and a major aspect of being a human is our subjectivity, we also need to pay far more attention to subjective phenomena, even those difficult to define reliably [Strauss, 2005].

1.2. Relevance of psychopathology in cultural content

Karl Jaspers who was a psychiatrist and a philosopher, as well as a major contributor to Existential psychoanalysis and to the content of psychiatric patients’ delusions suggested applying cultural assessment of the sick individuals [Jaspers, 1950]. Cultural competency is now a core requirement for mental health professionals working with culturally diverse patient groups [Bhui et al., 2007]. After long years of the Soviet occupation, along with political and economical changes, Lithuania has become free and open for other cultures, patients’ from different countries entry the local health care system. In this situation, cultural assessment should be essential in order to a better understanding of psychiatric patients. Cultural identity, including language, religion, attitudes,
leisure, food choices and aspirations, influence distress, and the clinician will benefit from exploring this in a systematic manner [Bhui & Bhugra, 2004]. Post raises the question of the problematic of respect for religious meanings [Post, 1993]. In order to meet the demands of patients of diverse cultures, it is essential to add the dimensions of religion and spirituality to the training of future psychiatrists. As an extension of cultural psychiatry, which emphasizes the importance of understanding and respecting a patient’s lifestyle and value system, it is natural to consider the religious aspects of a patient’s life and respect the patient’s beliefs, whether spiritual or atheistic, rather than imposing the views and judgments arising from the therapist’s own religious views and attitudes [Post, 1993]. Lack of understanding of personal beliefs, values or cultural factors could lead to misinterpretation of phenomenology of rich bodily experiences and pushed into a black box of “summarization” [Jadhav, 2004]. Further more, these “somatic” experiences are edited and recorded in English language by local mental health professionals on (Maudsley derived) “Mental State Examination” proformas. In this situation, local worlds, their core moral and cultural values, and a rich vocabulary associated with bodily problems and expressed through a range of non-English languages [Lynch, 1990], are often glossed over or pruned to fit into conventional psychiatric nosology (ICD-10 and DSM-IV). This process of systematically acquiring a culture-blind ability is considered credible and meritorious, both locally and internationally. The exclusion of culture then systematically abolishes the ability (and sensibility) to consider the role of major social and cultural ‘variables’ that may well provide a phenomenological template and local forms of psychopathology to shape appropriate nosologies of distress [Kirmayer & Young, 1998].

Patient’s value system, beliefs and a need for spirituality should be known to a psychiatrist when dealing with his/her mentally ill patients. Nowadays, when psychopathology and normal states are becoming a mixture, humanistic and spiritual values are of great importance maintaining the mental health [Rudaleviciene, 2007].

Fabrega stressed that spirituality should be the main object in modern psychiatry, and he made a remarkable statement that psychiatry of the 21st century would have to be different from the psychiatry of the 20th century and should integrate all facets of knowledge of the behavioral sciences, biology, pharmacology, sociology, cultural anthropology, and to serve as providing expert scientific diagnosis and therapy in the light of an appreciation of the role played by cultural factors in shaping human behavior [Fabrega, 2001]. D’Souza suggested a need to include the spiritual and religious dimension of patients in their psychiatric care [D’Souza & George, 2006]. Religious roots as a foundation of spiritual powers of the individual play an important role on the life style chosen. Intensive efforts in the research on etiology and pathogenesis of schizophrenia and related disorders were performed by Emil Kraepelin (1904) and Eugen Bleuler (1924), but still the topic has been only partially clarified up today, thus many fundamental questions about the phenomenology of
delusions and hallucinations remain unanswered. Stompe noted that cross-cultural psychiatry studies have also tried, by means of its methodological inventory, to analyze the influence of biological and environmental factors on the pathogenesis and phenomenology of schizophrenia [Stompe e. al., 1999] The way a patients expresses his illness is influenced by his culture [Kortman, 2005], symptoms experience is embedded in the culturally based system of meaning and discursive practices [Bartocci, 2006; Kirmayer, 2005], the value and importance of understanding religious anamnesis and personal religious beliefs of psychiatric patients was reported [Brewerton, 1994; Campbell, 1998; Cohen, 2002; Browning, 2003; Mohr and Huguet, 2004; Rudaleviciene & Narbekovas, 2005; Boehnlein, 2006].

Before Eugen Bleuler (1924) renamed the disorder with the nosological term schizophrenia in the early 20th century, it was originally known as dementia precox (a deteriorating disorder occurring in adolescence and ending with dementia, in contrast to dementia senile). It is well known that Emil Kraepelin (1904), the founder of modern (descriptive) psychiatry, based on his organic orientation and descriptive approach, established a classification system for psychiatric disorders in the 19th century. He was curious as to how his classification system, which was based on the clinical observation of patients in Germany, could be applied to patients in other societies with diverse cultures. He traveled to Southeast Asia, including Indonesia, in the 1890 to make field observations and to test his classification system. Through his pioneering interest in the comparative psychiatry, he was relieved to learn that dementia praecox of a basically similar clinical picture found in other cultures, such as Indonesia. If there was any difference, it was of the variation of subtypes, e.g., catatonic cases were found more in Indonesia than in Germany.

At the present time we live in the world of process of movement and fusion of cultures. Lithuanian psychiatrists face foreign patients inside the country, as well as they face them in the other countries - as the emigration of Lithuanian doctors is a growing cultural phenomenon. There is a need for clinicians to have a knowledge and understanding of cultural differences in order to find a common language with patients and a way to understanding their psychopathology. Establishment of a multicultural dialogue is a challenge in the globalizing world.

1.3. Scientific novelty of the study

This study based on research into content of acute psychopathology, delusions and hallucinations is the attempt to open up a discussion about what content is reflected in the psychopathological phenomenon produced by our mentally ill patients suffering from schizophrenia. Novelty of this work could be explained by presenting a source of new information, as Prince said, locally observed: "local knowledge", which will add the database of the transcultural
material, is valued in the field of cultural psychiatry. Both Murphy (1982), and Prince (2000), main leaders of transcultural psychiatry in the 20th century, pointed out, that significant research often develops from the systematic exploration of even limited observations and from hunches and intuitions of prepared minds [Tseng, 2001].

Information presented in this research is new both for the world’s and for Lithuanian psychiatry. The impact of personal religiosity on the psychotic phenomena was not studied, this is the first attempt. The impact of culture on the contents of delusions and hallucinations was investigated a little before. Paranoid-hallucinatory syndromes in different cultures were described in this research. Guilt delusions in Catholic patients with schizophrenia and in Muslim patients with schizophrenia were described and compared.

Data of Lithuanian patients with schizophrenia for the first time were represented at the international scientific discussion of transcultural psychiatry for comparative studies. Research data entered the international scientific dialogue and became an input for the database of the transcultural comparative studies.

Subject of cultural psychiatry was introduced into Lithuanian psychiatry. Questionnaire on the research of the content of psychotic symptoms was adapted and suggested. This research about the psychotic phenomenology is the first one in Lithuania.
2. GOAL, OBJECTIVES, AND STATEMENTS TO BE DEFENDED

2.1. Goal of investigation
The goal of this study was to find out and assess the content of delusions and hallucinations in the patients with schizophrenia, and to examine the impact of personal religiosity and culture on these psychotic phenomena.

2.2. Objectives of investigation
1. To evaluate the impact of personal religiosity on presence and the content of religious delusions in patients with schizophrenia.
2. To evaluate the impact of personal religiosity on presence and the content of the world end (apocalyptic) delusions in patients with schizophrenia.
3. To evaluate the impact of personal religiosity on visual hallucinations in patients with schizophrenia.
4. To evaluate the impact of culture on psychotic symptoms in schizophrenia.
5. To evaluate the specificity of paranoid-hallucinatory syndromes in schizophrenia in different cultures.
6. To evaluate the prevalence of delusions of guilt in Catholic patients with schizophrenia and to compare with delusions of guilt of Muslim patients with schizophrenia.

2.3. Main hypotheses of the investigation
1. Patients with schizophrenia for whom their faith is of personal importance compared to patients with schizophrenia for whom their faith is not of personal importance will have a higher prevalence of religious delusions.
2. Patients with schizophrenia for whom their faith is of personal importance compared to patients with schizophrenia for whom their faith is not of personal importance will have a higher prevalence of the world end delusions.
3. Patients with schizophrenia for whom their faith is of personal importance compared to patients with schizophrenia for whom their faith is not of personal importance will have a higher prevalence of visual hallucinations.
4. Psychotic symptoms of schizophrenia are influenced by culture.
5. Content of paranoid-hallucinatory syndromes in schizophrenia will differ in different countries.
6. Catholic patients with schizophrenia as compared to Muslim patients with schizophrenia have a higher prevalence of delusions of guilt.
3. REVIEW OF LITERATURE

3.1. The pathoplastic effect of culture on psychotic symptoms in schizophrenia

Schizophrenia is a chronic, relapsing, remitting, debilitating psychotic disorder with protean manifestation, with significant morbidity and mortality. Schizophrenia has long been recognized as a devastating disorder for patients and their families. Symptoms of schizophrenia involve multiple psychological processes, such as perception (hallucinations), ideation, reality testing (delusions), feelings (flatness, inappropriate affect), behavior (catatonia, disorganization), attention, concentration, motivation (a volition, impaired intention and planning) and judgment. These characteristics are associated with impairments in multiple working, interpersonal relationship and living skills), a comorbidity of substance abuse (33%), suicidal attempt (40%), and suicide (10%). This disorder is noted in great heterogeneity across individuals and variability within individuals over time. The onset of schizophrenia occurs during early adulthood [Kaplan et al., 1994; Hertz, 2000; Tsuang & Faraone, 2000; Tsuang, 2002].

According to ICD-10 classification of mental and behavioral disorders, schizophrenia is characterized by gross disturbances of thought, perception and affect, in the face of clear consciousness [WHO, 2004]. Tsuang defines schizophrenia as a neurobiologically based disorder whose etiology is rooted in a combination of genetic and environmental factors [Tsuang & Faraone, 2000; Tsuang 2002].

Contemporary psychiatry attempts to clarify etiological and pathogenetic aspects of a number of suspected “biological” disorders, like severe affective disorders and schizophrenia, primarily by means of biomedical methods. But there are phenomena like contents of delusions which cannot be easily explained by biological or allied socio-medical sciences. Although it is generally accepted knowledge that prevalence and shape of certain psychotic phenomena are influenced by cultural patterns, the degree of the pathoplasticity of these symptoms is yet unknown. After numerous studies performed and data analysis, Stompe confirms cultural psychiatry is as an important tool for the understanding and consequently for the treatment of patients with major mental disorders [Stompe et al., 2006].

Schizophrenia in so called developing countries is characterized by lower prevalence rates and better outcomes compared with schizophrenia in developed countries [Saha et al., 2005; Jablensky, 1987; Leff et al., 1992; Sartorius et al., 1986; Edgerton and Cohen, 1994; Hopper and Wanderling, 2000]. While the impact of culture on the better outcome is still under discussion [Patel et al.,
data on psychotic symptoms like content of delusions, hallucinations, or Schneider’s first rank symptoms evoke the existence of remarkable influence of culture.

For the contents of delusions the personal and cultural system of values of an individual is of particular importance. For example, delusions of grandeur can hardly be found in village communities where it is regarded as reprehensible and dangerous to strive for a given social level [Pfeiffer, 1994, Stompe et al., 1999]. While religious delusions and delusions of guilt are primarily found in societies with a Jewish-Christian tradition, these contents are infrequent in Islamic, Hindu or Buddhist societies [Kim et al., 2001, Murphy, 1967, Ndetei and Vadher, 1984a, Stompe et al., 1999 and 2006, Tateyama et al., 1998].

The first large study about the frequency of different kinds of hallucinations in a cross-cultural investigation was conducted in the 1960 ties [Murphy et al., 1963]. One of the central findings was that visual hallucinations as well as tactile hallucinations occurred most frequently in patients from Africa and the Near East. Nearly 20 years later, Ndetei and Vadher carried out a cross-cultural study including patients with schizophrenia from nine ethnicities admitted to a London hospital [Ndetei and Vadher, 1984c]. The authors found higher rates of both auditory and visual hallucinations in Non-European patients compared to English and Continental Europeans. To investigate the impact of the culture of origin and the environmental influences of the second home, Suhail and Cohrane compared a sample of patients from Pakistan living in their home country, with sample of Pakistani, who immigrated to Great Britain and with patients of white British origin [Suhail and Cohrane, 2002]. Patients living in Pakistan reported statistically significantly more often visual hallucinations and visualizations of spirits or ghosts compared with group than in the both British groups. These findings underline the major importance of the immediate environment on the phenomenology of hallucinations compared with the influence of culture.

Critical of the theoretical complexity of Bleuler’s approach to define schizophrenia, Schneider introduced the concept of “nuclear“ or “first rank“ symptoms, FRS [Schneider, 1992]. They include psychotic phenomena like delusional perceptions, audible thoughts, thought broadcasting, thought insertion, thought withdrawal, commenting and dialogue voices, made volition, and somatic passivity. The pathognomonicity of the FRS has been challenged, as their frequency was primarily dependent on the cultural context. The frequency of the FRS in general has been found to be low in a number of non-Western countries: 56.5% in Saudi Arabia [Zarrouk, 1978], 35% in India [Radhakrishnan et al., 1983]), 25% Sri Lanka [Pela, 1982], 26.7% in Malaysia [Salleh, 1992], between 31% and 43% among non-Western immigrant groups in England [Ndetei and Vadher, 1984c]. On the other hand, a study from Nigeria reported 60.3% FRS [Gureje and Bamgboye, 1987]. These differences could be due to different definitions of the single symptoms and the time
under study, because the FRS is not as stable as delusional contents. However, they could also reflect true cultural differences.

The discussion whether and to which extent the prevalence and shape of psychotic symptoms depends on culture has long tradition, also in German-speaking psychiatry [e.g. Lenz, 1964; Zutt, 1967]. Zutt established the term pathoplasticity in German psychiatry in order to describe the culture-sensitive part of the symptomatology of mental disorders. However, until today this term has a more or less metaphoric character [Stompe et al., 2006]. Although most professionals would agree that cultural pattern may influence psychotic features, it is an unsolved question to which extent the variability of psychotic symptoms is caused by culture in a wide sense) socialization, religion, symbols, values, but also climate or nutrition) [Stompe et al., 2006].

Stompe and his research group had studied the culture – sensitive proportions of the total variance of the three groups of psychotic symptoms in schizophrenia: content of delusions, hallucinations and Schneider’s FRS. These studies to be continued up date.

3.2. Paranoid–hallucinatory syndromes in schizophrenia

Psychotic symptoms had been studied by Vienna (Austria) Research Group in Cultural Psychiatry, conducted by professor Stompe. The research on socio – cultural influence on the phenomenology of schizophrenia has long tradition which can be traced back to Kraepelin. However, all former investigations focused either on delusions or hallucinations, although it is part of common psychiatric knowledge that both phenomena are strongly associated (paranoid–hallucinatory syndrome).

Until nowadays transcultural comparative studies on psychotic symptoms in schizophrenia have exclusively investigated the differences in the distribution of only one group of phenomenon like content of delusions [e.g. Kim et al., 2001; Murphy, 1967; Ndetei and Vadher, 1984a] or Schneider’s first rank symptoms [Guereje and Bamgboye, 1987; Ndetei and Vadher, 1984b; Pela, 1982; Radhakrishab et al., 1983; Salleh, 1992; Zarrouk, 1978].

In earlier papers Stompe have shown some regular associations between certain kinds of hallucinations and contents of delusions in patients with schizophrenia [Stompe and Bauer, 2004]. Visual hallucinations seem to have an affinity to religious delusions as well as to delusions of grandeur, while coenesthetic hallucinations occur primarily with hypochondriac delusions. These results are pointing to the existence of relatively stable paranoid-hallucinatory syndromes. According to Jaspers (1963) syndromes are symptom-clusters, which are taken as typical pictures of mental states and which allow to bring some order into the countless varied phenomena. They are
objective and subjective phenomena of a striking character with a frequent simultaneous appearance of their characteristic elements and coherence of these symptoms.

3.3. Cultural psychiatry research on delusions of guilt in schizophrenia

Biomedical methods are used in contemporary psychiatry to clarify etiological and pathogenetic aspects of a number of suspected “biological” disorders as severe affective disorders and schizophrenia. In this light, a theory of schizophrenia or bipolar affective disorders addresses genetic and environmental precipitating factors, pathogenesis, the course and outcome, as well as the response to medication. However, such phenomenon cannot be easily explained by biological or allied socio-medical sciences like epidemiology. One of the most prominent examples is in the more favorable course and outcome in schizophrenia in developing [e.g. Torrey, 1987; Jablensky et al., 1992; Warner, 1995]. Although there are many types of psychotic features in schizophrenia that cannot be explained by neurobiological mechanisms alone, the study was addressed only one of these psychotic phenomenon: the delusions of guilt.

From a philosophical point of view, guilt is a quality which accumulates rates within a person through their “evil” acts [Safranski, 1997]. Guilt and feelings of shame are known as “ethical emotions” which follow unmoral actions, omissions, or expressions of interpsychic conflicts [Stompe et al., 2001]. Since these emotions structure the variance of man’s interactional behavior, which is not determined by genetic programs, then feelings of guilt are to certain extent. A powerful and important factor upholding peace and stability in societies everywhere. Nevertheless, guilt is also one of the major anthropological constants that may be delusional processed [Baeyer, 1979]. In fact severe mental disorders like psychotic depression or schizophrenia are sometimes associated with such psychopathological phenomena as delusions of guilt or negative delusional identities [Stompe et al., 2001; Stompe & Ortwein-Swoboda, 2002]. In such cases, the experience of guilt has lost its original significance of regulation of conduct toward other people or transcending instances. Normal as well as pathological guilt is determined by a host of factors: cultural (e.g. honor system), social (e.g. education) and individual variances [Stompe et al., 2001; Tellenbach, 1983; Kimura, 1993]. In a study on major depression, the frequency of ethical feelings, delusions and feelings of guilt were compared in a study including 100 patients from Austria and from Pakistan [Stompe et al, 1999]. The results demonstrated that Pakistani patients reported significantly less feelings of guilt and no delusions of guilt.
3.4. Cultural and socioeconomic considerations

Schizophrenia has been described in all cultures and socioeconomic status groups studies. In industrialized nations a disproportionate number of schizophrenic patients are in the low socioeconomic groups. That observation has been explained by the downward drift hypothesis, which suggests that affected persons either move into a lower socioeconomic group or fail to rise out of a low socioeconomic group because of the illness. An alternative explanation is the social causation hypothesis, which proposes that stress experienced by members of low socioeconomic groups contribute to the development of schizophrenia [Flor-Henry, 1983; Kaplan et al., 1994; Tseng, 2001; Tsuang, 2002].

In addition to hypothesizing that stress of industrialization causes schizophrenia, some investigators have presented data indicating that stress of immigration can lead to a schizophrenic condition. Some studies report a high prevalence of schizophrenia among recent immigrants, and that finding has implicated abrupt cultural change as a stressor involved in the cause of schizophrenia. Perhaps consistent with both hypotheses is the observation that the prevalence of schizophrenia appears to raise among third-world population as contact with technologically advanced cultures increases [Kaplan et al., 1994].

Advocates of a social cause of schizophrenia argue that cultures may be more or less schizophrenogenic, depending on how mental health is perceived in the culture, the nature of patient role, the available system of social communication. Schizophrenia has been reported to be prognostically more benign in less developed nations where patients are reintegrated into their communities and families more completely than they are in high civilized western societies.

It has been observed on many occasions that socio-cultural variables affect the symptoms of mental disorder, in particular delusions. Suhail (2003) found that the content of delusions among Pakistani patients diagnosed as having schizophrenia varied with their socio-economic class, with delusions of power more common among healthy males and delusions of black magic and persecution more common among poor females [Bhavsar & Bhugra, 2008].

3.4.1. Epidemiology of schizophrenia

A sizable amount of literature exists on the incidence and prevalence of schizophrenia in different cultures. Of course, the data are confounded by variations in the methodology and, in particular, of the identification of “case-ness“ of schizophrenia. The range and prevalence is generally said vary between 1 and 10 per 1000. As regards cross-cultural variations in the incidence figures, there seem to be two schools of thought. On one hand, there are those who think that it varies within relatively narrow limits across societies and cultures. According to Leff (1981),
prevalence rates in developing countries “vary within relatively narrow limits“ and are quite comparable to rates for developed countries. On the other hand, there are others who think that there are wide differences, mostly when comparing developed countries. According to Torrey (1974), it is more in societies that had greater exposure to the Western influence. Murphy (1982) noted four-fold difference in the incidence rates across cultures. However, he concluded that the “non-Western way of life does not offer protection against mental illness to a point of making a marked difference in frequency“. According to Wittkower and Rin (1965), the prevalence of schizophrenia ranged from as little as 0.9 per 1000 population in Taiwan to as much as 9.5 in Sweden [Wittkower & Rin, 1965]. Dunham (1965), comparing 19 surveys, concluded that the prevalence rates were quite comparable, around 4.4 to 6.8 per 1000 population. In their landmark study Murphy and Raman (1971) reported the prevalence in Mauritius to be similar to that in England [Varma, 2000].

3.4.2. Manifestation of schizophrenia

Historically, a number of studies have been reported comparing the manifestation of schizophrenia across cultures. Devereux (1958) called schizophrenia an “Ethnic Psychosis“ of modern Western society and that schizophrenic thinking and behavior are “taught“ and “inculcated“ by modern civilization.

Dome of the classical earlier reports of transcultural differences in salient features considered typical of schizophrenia have been as follows: India: Catatonic rigidity, negativism and stereotypy have been reported to be common in India [Witkower and Rin, 1965]. So are somatic symptoms, use of body language, quiet behavior, control of anger and aggression. Confusion and perplexity are more common; intense emotional anxiety seldom seen. Hoch commented on emotional withdrawal as a socially sanctioned mechanism. Paranoid formations are less systematized than in Euro-Americans [Hoch, 1961].

In his seminal paper, Gordon (1934), cited in Witkower, 1971 talked about blunting, bizarreness and social hallucinations in schizophrenia in Africa and called it “a poor imitation of the European forms“ he also noted grandiose identification with God.

Hutterites. The Hutterites have been reported not to show severe regression, excitement or any extreme antisocial acts [Eaton and Weil, 1955].

Japanese. The Japanese have been reported to have more of ideas of reference and disturbance of thinking than Filipinos [Enright and Jaeckle, 1963]. Change in delusional content has also been reported in the Japanese, before and after WW II; focus of grandiose delusions having shifted from the Emperor to Americans.

Americans. There was reported to be a generally greater disruption of reality testing, hallucinations and bizarre ideas in Americans than the Japanese [Schooler and Caudill, 1964].
Italians vs. Irish. Comparing the Italian-Americans and the Irish-Americans, greater hostility, acting out, elation and bizarre mannerism, with no feeling of guilt and sin and more direct expression in the area of sexuality have been noted in Italians [Opler, 1995]; latent homosexuality, guilt about sexuality, ambivalent anxiety, fear and hostility in the Irish.

Christians and Muslims. Delusions of destructiveness and religious delusions have been said to be more common among Christians and Muslims [Murphy & Raman, 1971; Varma, 2000].

3.4.3. Outcomes of schizophrenia

The modern research in transcultural aspects of schizophrenia started with the famous Cooper-Carpenter UK-USA study in the late 1960s comparing schizophrenia on the two sides of North Atlantic. This has been followed by a number of World Health Organization collaborative exercises, for the first time simultaneously comparing several countries, representing both the developing and the developed world, using rigorous, reliable and comparable methodology [Varma, 2000].

Over the last few decades, a number of studies have been reported on the course and outcome of schizophrenia. Notable amount the long-term studies have been the Lousanne project of Harding, 1988, and Burholzli Hospital study of M. Bleuler, 1972 [Harding, 1988]. These studies were limited to a particular centre in a country and did not investigate trans-cultural differences. Hegarty, Baldessarini, Tohen et al. (1994) have presented a meta-analysis of schizophrenia research over the last 100 years. Several studies have shown that the outcome of schizophrenia is more favorable in developing countries, such as India, than in developed countries, such as in the United States. Murphy and Raman (1971) were the first to examine possible differences in outcome between Western developed nations and other developing or undeveloped countries. Comparing the non-white schizophrenic populations, they found that the subjects from Mauritius were relatively symptom-free at follow-up and were functioning normally in virtually every aspect of their lives. These subjects also had fewer relapses and overall better outcome at 12-year follow up. Nancy Waxler (1979) in her landmark study reported significantly good outcome.

Several studies have shown that the outcome of schizophrenia is more favorable in developing countries, such as India, than in developed countries, such as the United States. Murphy and Raman (1971) were the first to examine possible differences in outcome between Western developed nations and other developing or undeveloped nations. Comparing the non-white schizophrenic population of Mauritius with European populations, they found that the subjects from Mauritius were functioning normally in virtually every aspect of their lives. These subjects also had fewer relapse and overall better outcome at 12-year follow up. In fact, 60% were found to be leading “normal” lives at follow up. Nancy Waxler (1979) in her landmark study in a Sri Lankan population reported significantly good outcome [Varma, 2000].
3.5. Cultural psychiatry

Cultural psychiatry is a dynamic and newly developing subfield of psychiatry that focuses on the fascinating cultural aspects of human behavior, mental health, psychopathology and treatment. At the clinical level, cultural psychiatry aims to promote culturally relevant mental health care for patients of diverse ethnic or cultural backgrounds. This includes a culturally sensitive assessment, and understanding of psychopathologies and psychological problems, and culturally appropriate care and treatment. In terms of research, cultural psychiatry is interested in how ethnic or cultural factors may influence human behavior and psychopathology, as well as the art of healing. On a theoretical level, cultural psychiatry aims to expand our knowledge of human behavior and mental health problems transculturally, in order to facilitate the development of more universally applicable and cross-culturally valid theories. From an academic point of view, cultural psychiatry illuminates how ethnic factors influence human behavior, determine stress and coping strategies, configure psychopathology, and modify help-seeking behavior. Ethnicity and culture also work, consciously or subconsciously, to shape our clinical practices into what we call the art of healing [Tseng, 2001].

Cultural psychiatry is a clinical specialty sprung mainly from Europe and North America, in order to respond to growing concerns of ethnic minorities in high income countries. Academic psychiatrists pursuing the comparative question in international mental health, together with clinical ethnographies conducted by medical anthropologists contributed to it’s theoretical basis [Kleiman, 1987; Littlewood, 1990]. What at first appeared to be marginal specialty is no longer so. For example, the UK alone had witnessed a steady growth: its mandatory inclusion in mental health training curricula, several taught Masters courses, academic positions in universities, three dedicated journals; and more recently, lead papers in mainstream publications that debate the cultural position of the “biological“ itself [Timimi & Taylor, 2004]. Cultural psychiatry in the UK is now a specialty in its own right. Culture-blind ability is considered credible meritorious, both locally and internationally. The exclusion of culture then systematically abolishes the ability (and sensibility) to consider the role of major social and cultural “variables” that may well provide a phenomenological template and local forms of psychopathology to shape appropriate nosologies of distress [Kirmayer & Young, 1998].These are precisely the very issues cited by international community as relevant for the health and economic development of poorer nations.

Cultural validity apart, there is an additional reason that merits such an enquiry: mental professionals, particularly from low-income nations have often expressed surprise at the manner in which scholarly discourses on cultural psychiatry and medical anthropology remain confined to
academic institutions of high-income countries with little impact on changes in everyday clinical practice in their own settings. It is in this context that anthropologically informed methods of enquiry have potential to help establish clearer links between personal suffering and local politico-economic ideologies.

Cultural psychiatry research centers carry on their academic work and grant interested psychiatrists with courses in the UK, Canada, the USA, Italy, Austria, Finland, India, France, Sweden, Japan. There is a Section of Transcultural Psychiatry (WPA-TPS) within the World Psychiatric Association (WPA), and World Association of Cultural Psychiatry (WACP) inaugurated in 2006 during its first Meeting in Peking, China.

3.6. Religion as an integral part of culture

According to Cox, religion is a “container of culture” and therefore has to be more fully understood. The rituals, beliefs and taboos are profoundly important to the nature and structure of the society and are vehicles whereby values, attitudes and beliefs are transmitted between generations [Cox, 1986].

Religious experience is brain-based, like every human experience [Mohr & Huguelt, 2004]. With development of neuroscience, scientists are able now to explore the neural basis of spirituality and feelings [Pietrini et al., 2003].

Religion is one of the ways we understand the world and give meaning to our lives [Tseng, 2001]. There are numerous religions in different societies and even within the same society that directly or indirectly shape our lives and influence thought and behavior. They also impact psychopathology, on the one hand, and influence therapy, on the other. Thus, it is essential for clinicians to understand the nature of religion and how to deal with the important cultural aspects of belief and faith. For this reason, there is a renewed interest among psychiatrists and behavior and social scientists in the interrelation of religion, psychiatry and mental health [Bhugra, 1996; Boehnlein, 2000; Koenig, 1998; Neeleman & Persaud, 1995; Pattison, 1968]. It is very natural for cultural psychiatrists to be concerned with the religious aspects of our lives and behavior, as they closely tied to culture. It is very important to do any research of these aspects in Lithuanian psychiatry as well, as there is a void in this field.

Anthropological view, according Anthony F.C. Walace (1966), could be presented and defined as “belief and ritual concerned with supernatural beings, powers, and forces”. Another anthropologist, Clifford Greetz (1973), defined religion more elaborately as “a system of symbols that acts to establish powerful, persuasive, and long lasting moods and motivations in men by formulating concepts of a general order of existence and clothing these concepts with such an aura
of factuality that the moods and motivations seem uniquely realistic”. It is believed that religion exists in almost all human societies; however, different cultures, conceptualize supernatural entities very differently. Also, religion, like ethnicity or language, maybe associated with social divisions within and across societies and nations, and depicts its sociological view of religion.

From cross-cultural perspective, it should be pointed out that many people have an atheistic worldview and live without religions. This is attributed to their lifestyle and beliefs, on a voluntary basis; rooted in their childhood in cultural experiences; or related to official ideology and policy, such as in mainland China, or many countries who there occupied by the soviets.

Psychological view of religion describes it as response to unpredictable situations; others describe religion as an asset of life style, and seeing it as way to human excellence. Jung (1912) suggested that religion was a way to wholeness, and Erik Erikson (1963) saw religion as hope and wisdom. For Freud (1913), religion was fulfillment of an infantile wish.

In psychiatric practice it is very important to define where we face the personal religious beliefs and where psychopathology takes place.

Many psychiatrists suggest that religion may have certain positive elements from the standpoint of mental health. Religious beliefs are beneficial to mental health, providing faith, hope, and calm to a person’s mind. Nearly 95% of Americans reported a belief in God (of whatever nature) [Mohr & Huguelt, 2004]. Many studies indicated that higher levels of religious commitment are associated with enhanced feelings of well-being and a lower prevalence of mental illness (particularly evidenced by self-destructive behaviors such as drug and alcohol abuse). Religion has also been identified as a potential buffer against stress. Religious commitment also often plays a role in reducing suicide rates. Religious counseling should be provided for religious persons with mental illness. This is observed in different of religions, from ancient shamanism to contemporary religions. In many Western societies, Jewish and Christian clergy are often called upon to act as front –line mental health providers, especially regarding personal problems. Clinical experiences indicate that patients prefer to be counseled by therapists who share the same religious background.

After an intensive of the literature on religion and psychotherapeutic processes and outcomes, many psychiatrists pointed out that nonreligious and religious counseling shared most counseling-relevant values, but differed in the value they placed on religion. They commented that these religious differences affected clinical judgment and behavior, especially with religious patients. Religiously committed patients often had more reservations about being counseled by therapists with nonreligious or different religious backgrounds because they feared that the therapists would ignore their spiritual beliefs as bizarre, if not pathological, rejecting the idea of communicating with a higher power [Mohr & Huguelt, 2004]. In India religion is not only a sound example of a way of life, but is incorporated in daily therapies, including psychiatry.
Clinicians who do psychotherapy need to have religious knowledge and orientation in their clinical work and need to understand their patient’s supernatural belief-related problems and providing relevant psychotherapy. Positive and negative clinical expressions of spirituality among people were pointed out by counseling psychotherapists.

3.7. Religious psychopathology

Mental phenomena that are significantly colored by religion require judgments from both religious and psychiatric perspective. A large group of internationally well-known psychiatrists were invited to analyze the influence exercised by religious beliefs on their psychiatric theories and practices. The aim was to detect the possible ways in which a number of theologically organized theories on the origin and the purpose of life, the existential way of approaching both the material and immaterial world, the expectations on the end of mankind, the beliefs on the origin of the disease and on the ways to treat both physical and psychic disorders [Bartocci, 2006].

There has been a resurgence of interest in religious and spiritual issues in psychiatry in the past fifteen years, and much research on a wide variety of topics. Religious coping, the health-promoting effects of religion, forgiveness, and neural underpinnings of religious experience are a few of the many subjects that are high on the research agenda at the present moment. Professional organizations like the World Psychiatric Association, the American Psychiatric Association each have divisions devoted to psychiatry, spirituality and religion. These divisions organize meetings, support publications, and have elevated the professional level of this interdisciplinary field.

However, in spite of all these efforts the voice of theologians and the tenets of theology are hardly ever heard on these matters. That to say, theology has not been made co-responsible for the construction of a research agenda. In short, while psychiatrists have been talking about theology; it is far less likely to find the sequence reversed.

Most studies have tried to assess how religious beliefs and religious practices influence psychotic illness. The study of religious delusions and hallucinations with religious content is of interest because these symptoms may lead to violent behavior. Homicides have been perpetrated by patients who featured religious delusions; religiously deluded people have taken statements literally in the Bible to pluck out offending eyes or cut off offending body parts; antichrist delusions have led to violent behaviors. It is important to differentiate religious delusional and normal experiences. This could be performed on the basis of three criteria: (1) the patients self-description of the experience is recognizable as a form of delusion, (2) other recognizable symptoms of mental illness are present in other areas of the individual’s life i.e. delusions, hallucinations, mood or thought disorder) and the lifestyle, behavior and direction of the personal goals of the individual after the
event or after the religious experience are consistent with the history of a mental disorders rather than with a personally enriching life experience [Mohr & Huguel, 2004].

Most case control/cohort studies indicate that religious engagement protects against suicide [Hilton, 2002; Duberstein, 2004]. Ecologic studies [Neeleman, 1997, 1998, 1999] suggested in Western countries high levels of belief are associated with lower rates of suicide and that this is more marked in females than in males [Apter, 2008]. These lower rates appear to be mediated by reduced acceptability of suicide and are independent of ethnic, genetic, social and cultural. There is, however, some inconsistency in evidence: e.g. Marusic, 1998. The Jewish approach to suicide has undergone marked vicissitudes over 3,000 years of evolution. After being accepted and tolerated in biblical times it became sinful and excommunicable in Talmudic times. During the holocaust the act of suicide became a focal point of controversy in the face of an intolerable external situation. Apter performed a study on religious factors affecting suicide and concluded presence of both empirical and historical evidence for a major effect of religion on suicide [Apter, 2008].

Glas, who is a psychiatrist and a philosopher, states, that religious psychopathology offers one of the best illustrations of the idea that the nature of disease and the boundaries of the profession cannot be settled on purely objective grounds only. It is the nature of religious psychopathology to compel clinicians and theorists to become explicit about all kind of background ideas and assumptions- assumptions about what is to be ill or to have a disease, the concept of function and the nature of religion. Religious psychopathology challenges us to go one step further by overcoming the split between strictly objective and subjective accounts of disease; and the split between fact and value [Glas, 2007].

Braam states that effective or emotional aspects of religiousness are considered to be crucial in the association between religiousness and well-being, especially in later life. The emotional aspects of religiousness, can understood as pertaining to the God image, or better defined as the God-object-relationship, corresponding to feelings of trust towards God or to religious discontent. Braam discussed about associations between God image, depressive symptoms, feelings of guilt, and personality characteristics, such as defined by the Five Factor Model of Personality. He found that feelings of discontent towards God correlated positively with hopelessness, depressive symptoms, feelings guilt, and also with depressive symptoms assessed 13 years earlier [Braam, 2008]. Most facets of God image, positive, critical, and about punishment reappraisals were associated with more feelings of guilt. A possible explanation for the related to depressive symptoms is that both, throughout life, remain rooted in insecure attachment styles. Neuroticism was associated to feelings of anxiety towards God. Agreeableness was associated to perceiving God as supportive and to prayer. These findings persisted after adjustment for depressive symptoms. For the other three personality factors (Extraversion, Openness, and Conscientiousness), no clear pattern
emerged. As in studies about God image and Five Factor Model of personality among younger people, some of the current results were prominent [Braam, 2008].

Collection of the current research works of psychiatrist, published by Springer in 2008 and entitled “Hearing Visions and Seeing Voices” demonstrates an increasing interest in the field of religious psychopathology [Glas et al, 2007]. Such a title became as a suggestion by one of the authors, Bryna J. Levy and one of the co-editors, Moshe Halevi Spero. It could be undoubtedly noticed, and perhaps felt somewhat disturbed or disquieted by the fact that we seem to have erred in crossing the specific sensory metaphors and verbs appropriate to them. Typically, one hears voices and sees visions and not the other way around. Of course, there exists a peculiar neurological condition known as synesthesia, which accompanies certain kinds of tumors, epilepsies, and the ingestion of psychostimulant agents, that is indeed characterized by appearance of hallucinatory visions in response to olfactory stimuli and auditory hallucinations in response to optical stimuli, but it was not exactly this we had in mind [Glas et al., 2007]. Group of researches highlighted the multiple pathways that religious and psychological experience might take, pathways that, more than occasionally, are fare more complex than even the atypical possibilities alluded to in the title. The first reference to this possibly appears in the Bible, from whence the title of our book derives. At the epiphany, according to the Writ, ve-kol ha-am ra’u et ha-ko’lot, “. And all the people saw the sounds of the thundering, ”the sound of the shofar horn, and other auditory experiences [Exodus, 20:15]. Here, again: seeing sounds. Many editors have avoided confusion by translating the text as and all the people perceived the sounds of thundering: which certainly preserves the central intent of the description, but at the cost of underemphasizing the types of complexities that the authors have chosen to address. Glas assumes that the “heart” of the religious individual is fed by multifarious tributaries, including neural, psychic, and spiritual, it is obvious that any effort to chart the wide range between normative and non-normative, and between pathological versus inspired normal perception will require the willingness to hear visions, see voices and many additional atypical qualities of psychological experience [Glas et al., 2007].

The debate between psychiatry and theology is vulnerable and its subject is often very sensitive. By focusing on “psychiatric” aspects of biblical concepts and persons-at least, as far as the term is usually understood in its strictly clinical connotations-the attention could tend to become directed in a one sideway toward abnormality, toward psychopathological aspects of biblical figures. This focus, then, would lead to a preoccupation with the issue of normalcy and the boundaries of the concept of disease. It is beyond doubt that this dimension is important. One may even expect theology to make contributions to this debate. The unraveling of the nature and dynamics of religion, and of religious phenomena and events in the lives of biblical persons needs a context of tranquility in which different interpretative options can be kept open as long as possible.
Such a context is not served by premature debate about normalcy and abnormality of the phenomena under investigation, still this is a challenge for future mutual investigations between theology and psychiatry.

The recent statement made during the latest International Conference on Religious psychopathology at the Leiden University (The Netherlands), organized by the World Psychiatric Association Section on Religious Psychopathology in March 2008, was: ”Normals are the believers, and the rest- on the contrary” [Van Praag, 2008]. This asks for high criteria of human feelings and senses for both to be able to perceive religious experience as well as to understand the believers.

3.8. Image of Jesus Christ in psychiatric literature

*I have come that that they may have life, and that they may have it more abundantly* (Jn 10, 10) [The New Testament, 2006].

Could we define the teaching of Jesus as a psychotherapeutic model and following his suggestions, formulated later on into the 10 orders - the way of healthy life?

Karl Jaspers defines the importance of philosophical idea of religion, personal contact with God and in this way the importance of creating the source of hope.

According Jasper, the Passion of Jesus becomes a model, teaching us to bear the most unjust and inexplicable suffering, not to despair when we are forsaken, to find God, the last and only foothold, at the source of all things, to bear our cross with patience. For all suffering is sanctified through Jesus.

The imitation of Jesus takes on still another meaning when his ethical imperatives are taken as a norm, when purity and love are seen as God’s will. This attitude compels knowledge: even at best we experience our ethical inadequacy.

His message teaches men to keep their eyes open for absolute evil in the world and forbids complacency; it reminds men of the existence of a higher authority.

Enormous intellectual efforts have been made to confine the contradictory flow of this man’s life and thought in a systematic whole.

The experience of modern science brings about a state of mind, which we call the “scientific attitude“. For this scientific attitude knowledge also means knowledge of its own limits; it knows with certainty even its uncertainty, it sees the scope and the presumption of every method. It recognizes that its kind of cognition can succeed in every instance only through limitation and renunciation and can never reach the totality of Being.

Within its limits, science possesses compelling validity and is thus unavoidable. If we attempt to avoid it we become untruthful. The truth, which is accessible to us, however, embraces a wide
area outside the sciences, in philosophy and theology. Yet if this truth, in its statements, violates scientific cognition, it ceases to be truth.

The universal scientific attitude has become possible in our age and has been realized here and there as a state of mind. To be sure, all the sciences are paths toward it but even today this attitude has not been generally and reliably adopted. Scholars and scientists sometimes actualize it only in their own field of study.

The authenticity of Jesus’ suffering is historically unique. The pain and terror are not accepted with resignation or borne with patience; they are not veiled. He insists on the reality of suffering and expresses it. When, forlorn and forsaken, he is nearly dead with suffering, the minimum of ground he has to stand on becomes all and everything, the Godhead. Silent, invisible, unimaginable, hit is after all the sole reality. The utter realism with which the uncloaked horrors of this existence are portrayed implies that help can come only from the utterly intangible.

Jesus did not suffer passively. He acted, in order that his suffering and death should be a goad for men. The experience of modern science brings about a state of mind, which we call the “scientific attitude”. For this scientific attitude knowledge also means knowledge of its own limits; it knows with certainty even its uncertainty, it sees the scope and the presumption of every method. It recognizes that its kind of cognition can succeed.

Jesus Christ’s reality is clearly discernible through the veil of tradition. Unless we are willing to trust the fragmentary tradition and run the risk of error we shall be left with a mere critical investigation that dispels every shred of reality. We must start with our personal engagement in the story of Jesus. It is important his picture to ground in our own human relation to Jesus the man. What we know most certainly of Jesus is his message: the coming of the kingdom of heaven, what men do to prepare for it, salvation through faith.

A meaning is possible. For the end of the world will bring not nothingness but the kingdom of heaven. The kingdom of heaven: this signifies the era in which God alone will govern. Inevitably it will come not through any human acts but solely through divine actions. The world has become a matter of indifference because the kingdom of heaven is coming in all its glory. Hence the happy tidings: “Blessed are the poor in spirit, for theirs is the kingdom of heaven”. And “fear not little flock; for it is your Father’s good pleasure to give you the kingdom“. And the prayer: “Thy kingdom come“. Thus the end is not only a threat, the destruction of the world, but also a promise: the kingdom of God. The mood is one of mingled dread and jubilation.

God’s love of man and man’s love of his neighbor are inseparable. Only insofar as we love can we know God’s love. God’s love creates love within us. If we do not love, we are rejected.
Jesus put forward no new system of morality but purified the Biblical ethos and took it as seriously as if it were already fulfilled in God’s kingdom. He lived it without regard for the consequences in the world. For the world was soon to perish.

The end of the message is: Believe in the good tidings. Have faith.

Possible psychological aspects: In his Antichrist, Nietzsche describes Jesus as a psychological type, hypersensitive, prone to suffering and dreading it above all else. Thus reality was intolerable to him he could accept it only as a parable, a sign. The world he lived in was not a real world, but a world of vague, intangible symbols.

Hostility, opposition, the resistance of concrete things was intolerable to him. For Nietzsche this explains why he did not contend with the world, “and resist no evil‖ is the key to the gospel. In this maxim Jesus’ personal incapacity for struggle is set up as an ethical principle.

The only true reality is the inner reality, which is called life, truth, light.

The kingdom of God is a psychological state. It is not expected, but is present everywhere and nowhere. It is a state of beatitude, which cannot be demonstrated by miracles or by scriptures, which offers no promise or reward, but is own proof, its own miracle and reward. Its proofs are inner lights, feelings of pleasure and self-satisfaction.

Correspondence between K. Jaspers and R. Bultman on the matters of faith.

D.F. Strauss, who was one of the “Hegelian‖ theologians of the nineteenth century, in his famous 1835 work Das Leben Jesus (The Life of Jesus), considered Jesus as the one who exercised profound influence on the human imagination and a generally benevolent influence on the “moral sense“ of humanity.

Bultmann introduces Jesus Christ as a real historical person, Jesus from Nazareth, who was crucified under Pontius Pilot. About this figure almost nothing is know- or need to be known-except the historical “fact“ of his existence. According Bultmann, Christ must be known through faith rather than through historical collaboration. Bultmann stresses that the life of faith for contemporary believer is equally absurd-perhaps even more so because the parameters of knowledge are more limited: early Christians did not draw a clear dividing line between the natural and miraculous, between myth and history, natural law and supernatural exceptions. The resurrection of Jesus is an “event‖ of faith, not a historical fact. It will not yield scientific discovery. It exists as a “fact‖ in the life of faith or it does not exist at all. Yet Bultmann speaks.

As if this faith event is historical because of its historic significance for the believer. Only through the mythical conceptuality of a Redeemer, or an apocalyptic Son, could Paul and John convey in their time the saving significance of Jesus. Bultmann (1954) recognizes that their language is not our language, their three-stored cosmos not the world we live in, and their landscape-rich in spirits and demons but empty in scientific explanation-not one we can accept. The
function of theology is not to insist upon the myth but to infuse it with a meaning that resonates with modern experience.

Jaspers imagined crisis afflicting modern society as a question of meaning: science has proposed itself as an explanation of the form of the world, but the form cannot also be the content. For Jaspers, science and empiricism are useful in making the world readable but not to provide interpretation. Indeed, even scientific knowledge, if there is anything to it, is not a random observation of random objects, but only becomes operant in significant intellectual action (interpretation). Jaspers defined New Testament as a culturally bound product of a relatively narrow range of problems [Jaspers & Bultmann, 2005].

The absurd faiths of the modern era, ranging from astrology to theosophy, and from National Socialism to Bolshevism, suggest that superstition has no less power over the human mind today than it had formerly. Such permanent elements of human nature are universal, and have nothing to do with modern science no more than with similarly permanent elements of rationality. Absurd modern faiths may very well make occasional use of scientific results, without grasping their origin meaning.

Numerous psychiatrists as well as theologians of these days are doing the research and discuss personality of Jesus Christ and his place for a today human beings [Van de Beek, 2007]

3.9. Indian psychiatry

3.9.1. Significance of local religion and spirituality in Indian psychiatry

India is that place, where religion is a lifestyle and the main aspect when dealing with mental health issues. Any psychiatrist in India must do full justice to the great religions and philosophies of the country [Somasundaram, 1984]. Religion is a part of understanding psychiatric problems and dealing with them in India.

India is an ancient and great cultural, spiritual, and an anthropological laboratory. She has been the nursery of saints and sages, scientists, and founders of world’s major religions, and promulgators of profound philosophy. Nevertheless, to be satisfied with glory of the past is to turn into a fossil; but to interpret the old from a new point of view is to revitalize the past and bring in a current of fresh air into the present. Vyasa as a Colossus and Gita as his Almighty Creation stand out pre-eminently in India’s sculptural history and together with the Upanishads and Brahmasutra, the Gita forms the “prasthana trayi”, (scriptural trinity) [Beardsley, 1959; Dasgupta, 1969; Keswani, 1974; Rao, 1964].

Warren Hastings, the first Governor General of British India, in his preface to the first English translation of the Gita by Charles Wilkins (1785) two hundred years ago prophetically remarked:
The writers of Indian philosophies will survive when the British Domination in India shall long have ceased to exist, and when the sources which yielded of wealth and power are lost to remembrance. Called, “The Song Celestial” by Sir Edwin Arnold, this Vyasa’s “quintessence of scripture” has interested and influenced men and women down the centuries. To name a few: Emerson and Walt Whitman, Carlyle and Thoreu, Max Muller and Aldous Huxley, Tilak and Gandhi, Vivekananda and Aurobindo, Tagore and Radhakrishnan and several others high and low. Numerous Indian philosophers saw in Gita an echo of their own philosophical thoughts, and incorporated the Gita concepts into their philosophical framework. In this respect is like a Rorschach inkblot. To Aldous Huxley, the Gita “is one of the clearest and most comprehensive summaries of the perennial philosophy ever to have been made. Hence, it’s enduring value, not only for the Indians, but also for all mankind”. Many outstanding Indian psychiatrists were considerably influenced by Gita [Rao, 1964; 1978; 1984].

Hysteria and Schizophrenia in the parlance represent the split between and within the mental faculties Gita brings out beautifully the process of deterioration of personality a dementing phenomenon, in a few verses. This is a ladder of doom:

“krodhad bhavati sammohah
sammohat smrtivibramah
smrti bhramasad buddhinaso
buddhinasaat pranasyati“

“From anger proceeds delusion; from
Delusion confused memory;
From confused memory the ruin of reason;
Due to the ruin of reason he perishes“.

These lines appear as though taken out from any modern text book of neuropsychiatry.

Gita adds and accords a supreme place to that master of sentiments, namely, devotion-Bhakti. This triple approach, namely, action, knowledge and feeling, merging into one, which is a triumph of Gita over the earliest philosophical attempts, is the forerunner of the modern concept of tripartite mental functions, namely cognition (jnana), conation (karma), and affect (“ichha“ or emotionally tinged desires or bhakti) [Vivekananda, 1978]. This was the classification of major mental faculties offered to modern psychology by German philosopher Immanuel Kant. Homer had earlier drawn attention to these aspects of personality, as “noos“, “thymos“, and “psyche“. A harmonious blending and a concentrated action of this trinity of functions is a requisite for the healthy mind. Any breach between them or within them can lead to a pathological split in the mind [Rao, 1964; 1978; 1984].

The mind of man can be linked to veritable battlefield: “Mahabharata“. There is an endless war of forces within the mind between the good and evil, divine and demon, high and low, sreyas and preyas as, man and beast, between light and darkness, virtue and vice as represented in the Mahabharata war by cousins Pandavas and Kauravas. It symbolizes what Shakespeare’s Brutus
calls a state of “insurrection” in mind. The battle between the lower and the higher is the theme that Gita elaborates. It is for these types of battle, minor as well as major, that psychotherapy is offered.

This constant tussle the mind was called “psychosomachia“ by the ancient Greeks.

Sigmund Freud described the mind as comprising triple terrains of the conscious, subconscious and unconscious. His discovery of “unconscious“ (hidden part) has been hailed as a milestone in the history of medical science and as important in its significance as that of the discovery of the circulation of blood by the English physician, William Harvey. The 20th century view on the nature of man can ill-afford to ignore the role of the “unconscious", notwithstanding the non-Freudians. It is that part of the mind, which encages the animalistic and instinctive qualities that press for entry into conscious and acts as a springboard for motivation of behavior. This topographical model of mind by Freud represents the battlefield with clash of forces within them. “The discovery that memories, thoughts and feelings exist outside the primary consciousness is the most important step forward that has occurred in psychology since I have been a student of that Science“, says William James. “Within it are held those things that lie in the fringe of the stream of consciousness chiefly at its lower and the non-communicable level“. We all carry the burden of the past – the burdens of the anatomical past, behavioral past, and the cultural past. The neuroanatomists tell us that in our human brain the rudiments of the animal brain persist. Carl Jung talked about racial unconscious indicating thereby that we carried over the precipitate of memories of our entire past within our mental realm. The instinctual urges and suppressed desires rise upwards towards the conscious to be opposed by the “downward forces that are influenced by cultural, social, environmental, and personal leanings. The unconscious is a necessary component since everything cannot be held in the conscious. Contrary to the Vedantic and Gita view, Freud saw human nature as basically evil and ultimate destiny lay in sublimating it. Rousseau held that man by nature was good and it was the society that corrupted him. The unconscious need not always be the storehouse of evils and unacceptable. It houses the sparks of goodness as well as divinity. Too often we are unaware of them [Rao, 1984].

The mind, which is constantly blasted by the sensual desires, is highlighted in Gita. Freud was not far from this view of Gita. The turbulent senses carry away the mind violently.

“Indriyani pramathini haranti prasabhamb manah“
“Like a boat tossed about on the high seas by a gale, mind can be uncontrollable“
The difficulty of the control the mind is brought out in the line.
“Chanchalam hi manah Krishna pramathi balavad dhridam“
“The mind is restless, turbulent, strong, and stubborn. It is as difficult to control as wind“.

Gita advocated the attainment of state of evenness of mind – “samathvam“, its steadiness “stithapragna“ and peace “shanti“ comparable to the “steadiness of a lamp that flickered not in a windless place“ (“Yathadipo nivathas tho naiṅte“). Anunfrfrfled state of mind is compared to a
tortoise with its limbs drawn in („kurmo angani samharate“). A steady state of mind, sustenance of its peace has been the quest of the philosophies of all the lands. The Greeks called this “ataraxy“. Gita terms it „shanty“. Olser revived it in his „Aequanimitas“.

Sankara remarked that there are no devils other than those in the minds of man. The United Nations preamble stated that the wars start in the minds of man, and the essds of peace should be sown in the same place. These concepts are elegantly brought out in Gita:

“uddhared atmana tmanam na yamanam avasadayet
Atmaiva hy at mano badhur atmaiva ripur atmanah“

“Let a man raise himself by his own self,
Let him not debase himself. For he is himself his friend, himself his foe“.

“bandhur atma tmanas tasya yene tmaiva tmana jitah
anatmanas tu satruvet varteta tmai ve satruvat“

“To him who has conquered his base self by the divine, self, his own self is a friend,
But to him who has not subdued the self, his own self acts as the foe“

One’s own mind has a preventive and curative function. Healthy habits of attitude, thoughts, disposition and feelings can offer equilibrium. It brings out the fact of enormous resources that are available within for healing.61-the well being for man’s mental equipoise and his physical and social well-being has been the endeavor of the philosophies of all lands-from the spiritually oriented Vedas and Upanishadas to the materialistic schools of European Epicureanism. Vedic Saints, perhaps the most ancient among the class of thinkers, perceived an order in Nature [Rao, 1964; 1978; 1984].

3.9.2. Religion in Indian psychotherapy

Indian psychiatrists pay significant attention to doctor –patient’s relation, which should be effective essence of therapy brought out in the very beginning of the healing process. Instances are not wanting in history of medicine where wars have contributed for its advances. Gita’s message was delivered on the battle field, a better context than which would not be appropriate for the message of action. Rudyard Kipling said: There are only two classes of mankind-doctors and patients. Krishna and Arjuna are these dual representatives. Symbolically Krishna represents a master healer of the minds of humanity. His name itself literally means a “Plougher“, engaged in the process of ploughing the minds of men, and Arjuna symbolizing the patient in the state of anguish—“Soka Samvigna Manasah”. They exemplify a typical Guru-Chela, or a doctor-patient relationship [Rao, 1974; 1978]. The effective essence of therapy is brought out in the very first two verses addressed to Arjuna and stimulating him for action.
“Kutas tva kasmalm idam
Visame samupasthitam
Anarya justam asvargyam
Akirtikaram arjuna”

“Whence has this unmanly, heavenbarring and shameful delusion come upon you, at this juncture, o Arjuna”.

“Klaibayam ma gamash partha
nai tat tvayy upapadyate
ksudram hrdaya daurbalyam
tyaktvo ttistha paramtapa”.

“Yeald not, o Partha, to feebleness. It does not benefit you. Cast off this petty faint-heartedness. Wake up. O vanquisher of foes!”

The significant word in the therapy is "arise". This arousal is from three areas of inactivity - from ignorance to knowledge, from apathy to a positive feeling and from inertia to purposeful activity. Krishna urges Arjuna in several other ways to fight, e.g. ”Tasmad Yudhasya Bharata”. Gita brings out the ingredients of the relationship so well that Krishna considers his pupil as a friend capable of intelligent interrogation and exercising the power of discrimination. There is on the part of Arjuna a total sense of surrender and readiness to be instructed and to be told what is to be done. This is exemplified in the verse:

“karpanyadosopahatasvabhavah
prechami tvam dharmasamuddhaceta
yac chreyah syan niscitam bruhi tan me
sisyas teham sadhi mam tvam prapannam”.

“my nature is weighed down with the taint of feeblemindedness;
my understanding is confused as to duty.
I entreat you, say definitely what is good for me.
I am your disciple. Do instruct me who have taken refuge in you”.

The Lord wears a tranquil countenance with a disarming smile while Arjuna is dejected and torn between intellectual doubts, ethical dilemma, and filial bondage. The Greeks spoke of “Filial” that is, a loving friendship between the doctor and the patient. Gita brings the dual aspects of the concept of surrender, namely, the qualities of the surrendering individual and the demands of the one to whom one surrenders. The Lord after teaching many ways ultimately urged Arjuna to come to him abandoning everything and that He would lead him. The master and the pupil in Gita display this which is extremely necessary for a wholesome rapport. The counseling on the battle field
represented a crisis intervention and a good single-short therapy. The therapy has the offeca of converting a withdrawing warrior saying “Na Yothesya”, into a hero cleared of doubts declaring “Thine will be done”. The therapy ends with cleared doubts declaring:

“Nasto mohal smritir labdha
tvatarasadan maya cyuta
sthi to smi gatasamdehah
karisy vacanam tava”.

“My delusion is destroyed. I have regained my memory. I am firm; I am free from doubt. I shall act according your word. I have regained my memory through Your grace“ [Rao, 1984].

This transformation of a splintered personality into synthetic and wholesome one represented essence of success of therapeutic alliance. Freud said that in psychotherapy the patient should be made to become “his real nature and not ourselves“ [Rao, 1984].

This transformation of a splintered personality into synthetic and wholesome one represents the essence of success therapeutic alliance. It should not be forgotten that the Master did not force the ideas on the pupil but suggested to him that he has taught him certain things but it was up to the latter to act as he likes. Freud said that in psychotherapy the patient should not be made to become “his real nature and not ourselves”. It may be seen that the final decision to act is taken by Arjuna while Krishna only cleared his doubts.

Modern students of family dynamics cannot fail to discern an element of double-bind phenomenon of Bateson in Lord Krishna’s advice. Arjuna perhaps is left with no alternative than to fight. The immense potentiality in resources of human mind is brought about in the discourse. Considered from all these points of view Gita is a masterpiece of psychotherapy touching upon every aspect of mental activity [Rao, 1978].

Gandhi, a world famous Indian leader, had strong religious beliefs, who led him over his life and every day’s practice. He is an example, of strong power of personal religious beliefs and practice. He left the writings, where he shared his experience:

“There is an indefinable mysterious Power that pervades everything. I feel it though I do not see it. It is this unseen Power which makes itself felt and yet defies all proof, because it is so unlike all that I perceive through my senses. It transcends the senses. But it is possible to reason out the existence of God to a limited extent” [Gandhi, 1949]. His beliefs in God became his life style what was the power of all his achievements.

Another world famous Hindu personality, Rabindranath Tagore, the winner of the Nobel Prize in 1913 for his Lyrics “Gitanjali” is one more example of incorporation of religion in person’s life. William B. Yets, a poet, world famous poetry classic, who was the first translator of Gitanjali from
Bengali into English, confessed in his introduction about his extraordinary experience of becoming close to God, while reading these songs. Poems of Gitanjali were introduced as prayers.

R. TAGORE

Gitanjali

That I want you and only you- let my heart repeat without end. All desires that distract me, day and night, are false and empty to the core.

As the night keeps hidden in its gloom the petition for light, even thus in the depth of my consciousness rings the cry - ‘I want you, only you’.

As the storm still seeks its end in peace when it strikes against peace with all its might, even thus my rebellion strikes against your love and still its cry - ‘I want you, only you’ [Tagore, 1913].

When you commandest me to sing it seems that my heart would break with pride; and I look to your face, and tears come to my eyes.

All that is harsh and dissonant in my life Melts into one sweet harmony - and my Adoration spreads wings like a glad bird on Its flight across the sea.

I know that you takest pleasure in my singing. I know that only as a singer I come before any presence.

I touch by the edge of far spreading Wing of my song your feet which I could never Aspire to reach.

Drunk with the joy of singing I forget Myself and call you friend who art my lord [Tagore, 1913].

India is full of similar experiences. Hindu textbook of psychiatry is full of explanations of different religious phenomena, literature heroes and explanation of their incorporation into the daily psychiatric practice. Professor Cox, who is one of leaders of the World Psychiatric Association, has presented his experience of visiting psychiatric conferences in India: “A western psychiatrist
attending a conference in India or Pakistan may therefore be surprised when religious practice (including prayer, invocation and exhortation) is included in scientific programmes. Such an experience being an acute reminder of the extent of secularization within a Western society, in which religious practices are now less commonly encountered in hospitals or professional meetings” [Cox, 1986].

3.9.3 Significance of christianity in Indian psychiatry

Many people believe that Christianity came to India along with the foreigners from the West. In actual fact, Christianity in India is older than in the West, having been brought here by no less a person than St. Thomas, one of the twelve Apostles of Jesus Christ [Sacred Scripture, 1990]. According to tradition, and the writings of travelers such as Marco Polo, he came initially to the Jewish communities already established in Malabar (Kerala), and converted some of them to Christianity. He also preached to the local people and established seven churches locally. He was martyred near Madras (at St. Thomas Mount), and his tomb is in the Cathedral at “San Thome“, Mylapore, which is a suburb of Madras. These early Christian churches flourished, side by side, with Hindu temples. When the Portuguese came to India in about 1500 A.D., they estimated that number of “Thomas-Christians“ was about 1,50,000. They formed a well-integrated community, and also enjoyed a high social position among their neighbors. St. Francis Xavier arrived in India an 1554, A.D., and visited almost all the villages and towns from Kanyakumari (Cape Comorin) to Quilon, teaching children and adults to live as good Christians. The Indian Christians adopted western social customs as well, and thus became almost alienated from their non-Christian brothers. However, at the call from Mahatma Gandhi, the Indian Christians responded and participated in the struggle for Independence. Christian Medical Institutions, established in the country, contributed greatly to the advancement of the psychiatric services in India.

The Indian Christian community is fairly well integrated into the social and cultural characteristics of the general Indian Society. Many customs like the caste system and dowry (now illegal), pervade in this community too. Some Christians have cultural beliefs in superstitious practices like astrology and palmistry, and also in “Black magic“, or “the evil eye“, etc. In the past, religious scrupulosity and obsessions about sin were often seen, but these are seen much less now, perhaps due to the new vision and teaching since the second Vatican Council. In general, however, the Indian Christian psyche appears to be more resistant to mental ill-health than the other communities. This may be due to the strong religious faith of most of the members of the Christian community. One tragic consequences of the westernization of the community is the increased prevalence of alcoholism among its members. This is a serious problem which is engaging the attention of the Christian therapist.
The most important impact of Christianity on psychiatry is that it has been able to bring the religious and cosmic dimensions into the understanding and care of mentally ill. It is generally accepted that mental illness occurs at five inter-related levels, i.e., the cellular level, the organ level, the total person level (body, mind and spirit), the social level (family and community) and the cosmic level, (world, wide and metaphysical, dimensions). Many mental health professionals while accepting these dimension, are at a loss how to deal with some of them. For example, if there is a problem of guilt, it is often denied or ridiculed, or the patient is referred to a priest. The Christian psychiatrist or counselor, who has been able to integrate psychology with Christian spirituality, is able to help the Christian patient (and even non-Christian ones) considerably. How often has a depressed patient who feels that no one loves him, been helped to recovery on being reassured about the love of the God who created him [D’Netto, 1984].

Christian psycho theology (a term found in the Indian Text book of Psychiatry – nowhere else) is able to provide absolute values and guidelines for psychotherapy. One of the biggest problems among young all over the world, and also in India, is Durkhiem’s “Anomie“. Youth asks, “Who am I? why I was born?” and receives no satisfactory answer. The problem of the poor self image of many patients is a stumbling block for many secular therapists. How often has the block removed by the insight that “God does not create junk“. In the first chapter of the Bible, a powerful psychotherapeutic tool when it repeatedly asserts, “God saw that it was good“, till finally at the creation of Man, it asserts, “God saw that it was very good“ (Genesis: 31) [Sacred Scripture, 1990].

Christian psycho theology has also been able to differentiate neurotic guilt from healthy guilt. Whereas healthy guilt helps the person to repent and accept his responsibility for wrong action, neurotic guilt is paralyzing and self-defeating. Secular psychology and psychiatry attempts to dismiss all guilt as unhealthy and unnecessary which has been unacceptable to many patients [D’Netto, 1984].

While Freud emphasized anxiety as the basis emotional illness, Christian therapists have found that anger, resentment, and hatred are even more important seeds of mental illness. Anger turned. Upon the self is often the root cause of depression. Christian psychotherapy focuses on healing through forgiveness, unlike secular therapies, which attempt to exteriorize those feelings by self-expression and ventilation, which in turns leads to more guilt. Especially in the families, as any expression of anger against parents, life partners, children or other authorities, is often considered and appear a sacrilege, and hence unacceptable.

Finally, whereas Western secular psychotherapy attempts to separate religious beliefs from the therapy, Christian therapist in India try to integrate the strong religious faith of the people into the treatment.
Even integrated Christian principles with yogic forms of meditation have been quite successful in the training and formation of religious men and women, provided the basic personality healthy.

There are several Christian shrines of worship, which attract thousands of people who need physical, psychological or spiritual healing. At these shrines, people of all religious, castes and communities mingle together to pray for healing. The prayer services are usually in the form of novenas and community worship.

There was a tremendous renewal among Christians in general, and Catholics in particular. One of the noteworthy features of this renewal is the healing ministry associated with it. Christians involved in the Charismatic renewal believe in the healing power of the Risen Christ and Holy Spirit. Relying on the words of Jesus, that his followers will “lay their hands on the sick and they will recover” (Mark, 16:18) [The New Testament, 2006], the prayer groups reach out to sick people in prayers for healing. These prayers have resulted in physical healing in many cases, but more important have been the “inner healing”, of mind and spirit. Recognizing that, by oneself, a person is often unable to get rid of anger and other negative emotions, they pray that Jesus will heal the harmful and hurtful Memories that have caused them and thus eradicate the sickness. There have been several genuine healings in the lives of alcoholics, drug addicts, and those with sexual problems, as well as among the neurotics and psychotics who till then, had not responded to the usual psychiatric treatment. The emphasis in all this healing is repentance and reconciliation with God and neighbors so that the person is led to anew life in Jesus Christ [D’Netto, 1984].

Christian therapists in India have been increasingly concerned and involved with growing number of people, especially youth, who come to India in search of peace and mystical experiences. It appears that most of these young people are disillusioned with the materialistic society in their own countries, the collapse of family and community life there, and the failure of religion to provide spiritual guidance and consolation.

Although the Christian Community in India is a minority, its impact on psychiatry in India is very significant. This is possible because the faith dimension of the people of India, and the ability of the Christian therapist to integrate psychological principles with spirituality in a measure, which has not been possible in the West [D’Netto, 1984].

Hindus state, that “each soul is potentially divine. The goal is to manifest this divine within, by controlling nature, external and internal. To do this either by work or worship or psychic control, or philosophy by one, or more, or all of these - and be free. This is the whole of religion. Doctrines or dogmas, or rituals, or books, or temples, or forms, are but secondary details” (Vivekananda, 1955). This is the essence of Indian religion which expresses worship of every human being and offers great possibilities. The same idea could be found in the teaching of Jesus Christ, who stayed a
divine law of “love for one’s neighbor“, what could be worth to “sacrifice ones life for” [Sacred Scripture, 1990].
4. SUBJECTS AND METHODS

4.1. Subjects

This research consists of two parts.

The Lithuanian study is a part of the research project entitled “Research in Cultural Psychiatry. Research of the Content of Delusions and Hallucinations”. This part includes 301 patients with schizophrenia consecutively admitted to the Vilnius Mental Health Center (Lithuania) during the period of six months, from September 2006 until February 2007. Patients with schizophrenia, who met the inclusion criteria, 295 (98%). were included into the analyses (the mean age – 42.4 (SD 9.7) years; women – 152 (51.5%). This was a consecutive and randomized research. The Protocol of the study was approved by the Lithuanian Bioethics Committee. All patients of the study signed the informed - consent form.

The second part, a sub-study, is a part of the International multi-centre comparative study on transcultural aspects of psychotic symptoms, performed by the International research group conducted by professor Thomas Stompe at the Vienna Medical University. The data were obtained from Austria, Poland, Lithuania, Georgia, Pakistan, Nigeria, and Ghana.

Table 4.1. Demographic and clinic data of patients with schizophrenia in the international multi-centre comparative study (N-total = 1080)

<table>
<thead>
<tr>
<th>Country</th>
<th>Male N (%)</th>
<th>Female N (%)</th>
<th>Age(^a), years</th>
<th>Age at onset(^a), years</th>
<th>Duration of illness(^a), years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria (N=350)</td>
<td>258 (73.7)</td>
<td>92 (26.3)</td>
<td>33.0±10.0</td>
<td>22.3±6.4</td>
<td>10.6±9.1</td>
</tr>
<tr>
<td>Poland (N=80)</td>
<td>59 (73.7)</td>
<td>21 (26.3)</td>
<td>28.1±7.2</td>
<td>22.5±6.4</td>
<td>5.5±6.0</td>
</tr>
<tr>
<td>Lithuania (N=73)</td>
<td>33 (45.2)</td>
<td>40 (54.8)</td>
<td>35.3±13.1</td>
<td>23.2±6.1</td>
<td>12.1±10.5</td>
</tr>
<tr>
<td>Georgia (N=74)</td>
<td>37 (48.7)</td>
<td>39 (51.3)</td>
<td>37.2±10.9</td>
<td>25.9±7.5</td>
<td>12.8±10.5</td>
</tr>
<tr>
<td>Pakistan (N=103)</td>
<td>65 (63.1)</td>
<td>38 (36.9)</td>
<td>32.8±9.6</td>
<td>25.2±7.0</td>
<td>7.7±6.4</td>
</tr>
<tr>
<td>Nigeria (N=324)</td>
<td>198 (61.1)</td>
<td>126 (38.9)</td>
<td>30.8±10.9</td>
<td>25.1±8.3</td>
<td>6.3±7.5</td>
</tr>
<tr>
<td>Ghana (N=76)</td>
<td>39 (51.3)</td>
<td>37 (48.7)</td>
<td>33.8±9.9</td>
<td>25.9±7.5</td>
<td>7.9±6.6</td>
</tr>
</tbody>
</table>

\(^a\) Mean±SD (Standart deviation)

Data on total 1080 schizophrenia patients from seven different countries, including 73 schizophrenia patients from Lithuania, were analyzed and compared (see Table 4.1).

4.2. Methods of the study

Ethics

Application for the permission to perform this research was signed by the Director of the Vilnius Mental Health Center (Lithuania). The Protocol of the study was approved by the Lithuanian Bioethics Committee. Information about the protocol and the research design was
distributed among all doctors and nurses, and psychologists of the Center during the meeting and rounds. All patients of the study signed the informed-consent form.

**Inclusion criteria**

Patients were included into the study if they met following criteria: established clinical diagnosis of schizophrenia, schizoaffective disorder or schizotypal disorder according to the criteria of the International Statistical Classification of Diseases (ICD-10), age between 18 and 80 years, male and female, who were capable of participating in a productive interview according to their mental state.

Patients from the six departments of the Vilnius Mental Health Center were included into the study: the department of acute psychoses for female patients, the department of acute psychoses for male patients, the department of sub-acute psychoses for female patients, department of sub-acute male patients, the daycare department, and the consultant department of psychiatry. Patients were selected for the interview by the head psychiatrist of the department. Those patients who were diagnosed having schizophrenia, schizoaffective disorder or schizotypal disorder – what is further called by the uniform term ‘schizophrenia’ – were invited for the research interview. This was a consecutive and randomized research. Patients were instructed about the research protocol, the form of agreement was given to read to every participant, investigator answered all questions asked by the patients and explained every detail they were inquired. After this procedure, patients who agreed to participate in the study signed the form of consent, in front of the two witnesses, who also signed the form. Every form of consent was signed by the Director of the Vilnius Mental Health Center. Every patient was interviewed by the same psychiatrist, a researcher. This was face-to-face interview.

**Questionnaire**

Content of delusions, hallucinations and Schneider’s first rank symptoms were evaluated by the means of the “Fragebogen für psychotische Symptome” (FPS) - a semi-structured questionnaire developed by the Cultural Psychiatry International research group in Vienna [Stompe et al., 1999; Stompe, 2001; Stompe & Ortwein , 2002b; Stompe et al., 2003; Stompe et al., Stopme et al., 2004b; Stompe & Bauer, 2004].

The FPS consists of four parts: the introduction that contains questions on demographic and clinical data; and the three modules describing different symptoms of psychoses as mentioned above: content of delusions, content of Schneider’s first rank symptoms, and the type and content of hallucinations. The whole questionnaire is attached in the annexes 3 and 4.
The section on *contents of delusions* comprises 10 themes (persecution, poisoning, grandeur, religion, hypochondria, guilt, apocalypse, erotomania, jealousy, descent); multiple quotations were possible.

The chapter on *hallucinations* comprises six types (auditory, visual, coenesthetic, tactile, gustatory and olfactory) and characteristic qualities (content, complexity etc.).

The chapter on *Schneider’s first Rank Symptoms* contains questions on the occurrence of delusional perceptions, audible thoughts, thoughts broadcasting, thoughts insertion, thought withdrawal, commenting and dialogue voices, made volition (“made thoughts”, ”made emotions”, “made movements”, ”made actions”).

All items were binary coded. Additionally, each answer has to be noted in descriptive part. Possible periods under investigation, a) point prevalence, b) one year prevalence, and c) life time prevalence.

The FPS was translated into Lithuanian using of the method of double translation. English version of the FPS was translated into Lithuanian by a psychiatrist, and English language professional, and translated back to English by another professional translator. Translation and back translation was discussed between the psychiatrist and the English language professional. FPS back translation to English was sent to Vienna for review and approval by the authors of the instrument.

Kappa index (0.87) was tested, repeating the same interview with several patients, after some time passed.

In addition to the FPS interview all patients were asked about their specified/identified religiosity, asking “Are you religious person?” Possible answers were “Yes” or “No”. Another question regarding religiosity was a request about their confession “According your religious beliefs are you: Catholic, Muslim, Buddhist, Hindu, or Other religion?” The third question regarding religiosity was about the personal importance of religiosity: “Is your faith personally important for you?” with possible answers “Yes” or ”No”. Patients were also asked: “Do you have the possibility to realize your religious feelings?” Possible answers: ”Yes “or “No”.

**Evaluation of religious delusions**

Concerning evaluation of religious delusions, from the FPS we took a question describing the religious content of delusions ”Did you think you were an important personality, a saint, God, the devil or a demon?” with two possible answers “Yes” or “No”. In a case of the positive answer the patient was asked to describe specific content of delusion.

**Evaluation of the world end (apocalyptic) delusions**

For this study a FPS question about end of the world was asked:” Did you feel the world had come to an end or would soon come to an end? If yes, why and in what way?” Apocalyptic
delusions were further categorized (1 – Religious, 2 – Modern, 3 – Global) and analyzed on the basis of their content:

Religious – explain the world end according the Sacred Scripture, giving the answers as: “Jesus Christ will come and will not leave”; “brother goes against brother”; “nation will raise against nation”; “we come from dust and we return to dust”; “evil is dominant and God will judge us”; “the Bible says that Jesus Christ will come accompanied by sounds of buzzing trumpets”, “there is to much evil foretold in the Scripts, the God will pass judgment”, etc;

Modern – show many parallels with Sacred Scripture, but include signs from reality around, answers such as: “people very bad now-days, kill each other even schoolchildren use alcohol”; “there will be a war”; ”much terror, old and young are being killed, my wife has had an abortion”; ”abundant mafia will offer an explosion on the earth”, “was announced on TV”, “the priest said”, “it is possible, because there is no love anywhere, God is love”, etc.;

Global - “the world has gone mad; there is no need to be”; “there will be an accident in the Mazeikiai oil factory”; ‘I am an atomic war instructor - there will be more Chernobyl disaster”; “There will be tsunami“, “There will be total chaos”; “planets will collide”; “the Earth will explode” etc.

Evaluation of visual hallucinations

For evaluation of visual hallucinations, FPS question: “Have you ever experienced a vision or seen things which people have not?” was applied with possible answers “Yes” or “No”, - “If yes, which one?, If yes, - were there scenes or static pictures?”

Methods of the international multicentre study

International part of the study consists of data obtained from the International Study on Psychotic Symptoms (ISPS), conducted by professor Thomas Stompe from the Vienna Medical University.

Inclusion criteria were: a clinical diagnosis of schizophrenia in patients between 18 and 60 years of age, DSM-IV (APA 1994) diagnoses were evaluated by the use of the Structured Clinical Interview for DSM-IV-SCID. Psychiatrists interviewed those patients who had given informed consent.

Content of delusions, hallucinations and Schneiders’s first rank symptoms were evaluated by the means of the „Fragebogen für psychotische Symptome“ (FPS) - a semi-structured questionnaire developed by the Cultural Psychiatry International research group in Vienna [Stompe et al., 1999; Stompe, 2001; Stompe & Ortwein , 2002b; Stompe et al., 2003; Stompe et al., Stopme et al., 2004b; Stompe & Bauer, 2004].
The instrument was translated and retranslated into the several languages and checked for validity and reliability. Details of Lithuanian translation were provided earlier. After extensive intercultural dialogue and training in handling the instrument, inter-rater reliability was tested: case reports from each centre were sent by the internet to Vienna, randomized and distributed to the participating investigators. So no investigators knew the origins of the case report he/she was evaluating by the means of the FPS. The results were also returned to Vienna. Cohen’s kappa for inter-rater reliability ranged from 0.64 to 1.00 (delusions of guilt: 0.72) [Stompe et al., 2004b; Stompe et al., 2006]. Additionally, a wide range of socio-demographic variables like family structures [Stompe et al., 1999b], religious confession [Stompe, 1999; Stompe et al., 2006], social origins, education, marital status, and profession was determined from each subject.

To estimate the culture-sensitive proportions of the total variance of three groups of psychotic symptoms in schizophrenia (contents of delusions, hallucinations and Schneider's FRS), out of 1080 patients were randomly selected 73 patients from each centre, and discriminant analyses were performed separately for each symptom group.

Another multi-centre study on cultural aspects of schizophrenia was performed with the 1006 subjects (from six countries) evaluating delusions of guilt. Since it is often difficult to differentiate between pathological guilty feelings and delusions of guilt [Stompe & Ortwein, 2002a], delusions was defined according to the Viennese concept of delusions [Berner, 1982], where they are seen as complex structures of delusional ideas interpreted as "normal" with logical or illogical connections. The central distinctive feature of delusions is a subjective certitude without affective constriction, excluding mere coincidence. Delusions of guilt were classified by Fragebogen fur Psychotische Symptome (FPS). Further information concerning the impact of religious confession on delusions of guilt emerged from the analysis of self-accusing patients. Delusional guilt was analyzed in four different forms [Stompe & Ortwein-Swoboda, 2002a]:

**Negative Delusional Identity:** patients accuse themselves of having the identity of an evil historical personality (e.g. Hitler) or transcendent character like the Devil [Stompe & Strobl, 2000];

**Ontological guilt:** patients call themselves as an abstract evil for the whole world;

**Guilt of action:** patients report that they have committed terrible crimes in the past;

**Guilt of omission:** patients report that they have neglected their duties and brought bad luck to themselves or to their relatives.

**Statistical analysis of the data**

The statistical analysis applied a $\chi^2$ test for 2x2 and 2xk tables, Fisher’s exact test, Pearson and Spearman’s rank correlation, and logistic regression. Continuous or ordinal data were analyzed using $t$ test.
Between-group comparisons involving categorical data were evaluated using the $\chi^2$ statistic corrected for continuity. In cases where conditions of the $\chi^2$ statistic were violated (e.g. where cell frequency was $<5$), Fisher’s exact test was computed. Independent samples t-test was applied in cases with continuous data. Pearsonian correlation was established between dichotomies and continuous variables. Phi ($\phi$) (when both variables are dichotomies) and Cramer’s V (for larger tables) are used for analyzing the relationship between two nominal categorical variables. Significance levels were established at $p < 0.05$ (2-tailed.). Results are expressed as mean (and SD), median (and interquartile range [IQR]). Numerically, the categorical data are presented via frequencies (absolute number of items belonging to the category) or their proportion (percentage) in the sample.

The relationships of the analyzed determinants (age, sex, age-onset, duration of illness, birthplaces (urban, rural), marital status (married, single, divorced), education (no secondary, some post secondary), run of the illness (chronic or in attacks), age of parents at birth, the faith and the personal importance of the faith) with the development of delusions or hallucinations (dependent variable) were calculated in two stages: using the univariate and multivariate (applying Forward LR selection algorithm) logistic regression analysis. The data on the male and female subjects were analyzed separately, followed by the analysis of the total contingent of subjects. During the first stage of the analysis, we investigated all separate determinants, taking consideration the impact of the age, and included separate determinants and age into the logistic regression model. The quantitative evaluation of the impact of the studied determinants on the delusions or hallucination development (No, Yes)t was performed using the odds ratio (95% confidence interval (CI)) that shows the increase in the risk of a subject to enter the group of those experiencing delusions or hallucination with respect to the subject’s attribution to some of the classification categories of the studied factors with respect to the reference category. After that, the step-wise (Forward LR algorithm) procedure was used to include statistically significant variables into the model ($p>0.10$ – excluded). Goodness of fit was assessed with the Hosmer-Lemeshow test. Level of statistical significance was set at 5%. Statistical analysis of the data was performed using the statistical software package SPSS 11.5.

Statistical analysis of the international multi-center study

Statistical analyses were performed by using the $\chi^2$ test (with continuity correction when appropriate) and Fisher’s exact test (two-tailed) to evaluate the differences in the one-year prevalence of delusions of guilt in schizophrenia between patients from different cultural background and confessions.

Discriminant analysis is used to estimate the culture-sensitive proportions of the total variance of three groups (contents of delusions, hallucinations and Schneider’s FRS) of psychotic
symptoms in schizophrenia. There were randomly selected 73 patients from each centre, and were performed discriminant analyses separately for each symptom group in order to estimate the impact of culture on the one year-prevalence of the contents of delusions, hallucination and FRS. If discriminant function analysis is effective for a set of data, the classification table of correct and incorrect estimates will yield a high percentage of correctly classified cases. There were several reasons to apply discriminant analysis: a) to classify cases into groups using a discriminant prediction equation, b) to test a theory by observing whether or not cases are correctly classified, c) to investigate differences between or among groups, and d) to determine the most parsimonious way to distinguish between groups. The classification table is used to assess the performance of discriminant analysis. This is simply a table in which the rows are the observed categories of the dependent variable and the columns are the predicted categories of the dependent variables. If prediction is perfect, all cases will lie on the diagonal.

To identify existence of relatively stable paranoid-hallucinatory syndromes in schizophrenia a Principal-component analysis (PCA) was used to extract factors, the Varimax procedure to rotate factors, and the eigen value greater-than-one criterion to determine the number of factors. The loadings of .45 were considered "high" for dichotomous items. As the Lithuanian sample consisted of only 73 patients, a fact, which may lead to distortions of the factor structure because of the unequal sample size, 73 patients were randomly selected from all other sites for multidimensional analysis. For further analyses the standardized factor score were saved as regression coefficients (values between +1 and -1). To test the differences of the mean values between the samples of the single sites, One-Way ANOVA with Tukey post hoc tests were performed.
5. RESULTS

Demographic and clinic data of patients with schizophrenia

Socio-demographic data on 295 surveyed patients with schizophrenia are presented in Table 5.1. There was not found large gender difference. A significant difference was found in patient’s distribution according their marital status according the gender. Male patients were more likely to be divorced/separated than female patients.

Table 5.1. Demographic and clinic data of patients with schizophrenia

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>All a</th>
<th>Men b</th>
<th>Women b</th>
<th>χ², df</th>
<th>p c</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (SD), range, years</td>
<td>42.4 (9.7)</td>
<td>42.1 (9.9)</td>
<td>42.7 (9.5)</td>
<td>0.576 d</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(20-74)</td>
<td>(20-74)</td>
<td>(22-68)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of illness, years b</td>
<td>18 (13)</td>
<td>18 (13)</td>
<td>18.0 (13)</td>
<td>0.605 d</td>
<td></td>
</tr>
<tr>
<td>Age at onset, years b</td>
<td>25 (6)</td>
<td>25 (5)</td>
<td>25 (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at onset:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early onset ≤20 years</td>
<td>21.0 (62)</td>
<td>17.5 (25)</td>
<td>24.3 (37)</td>
<td>0.052</td>
<td></td>
</tr>
<tr>
<td>Middle onset (21 - &lt;35) years</td>
<td>76.6 (226)</td>
<td>81.8 (117)</td>
<td>71.7 (109)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Late onset (35 - &lt;60) years</td>
<td>2.4 (7)</td>
<td>0.7 (1)</td>
<td>3.9 (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>28.8 (85)</td>
<td>21.7 (31)</td>
<td>35.5 (54)</td>
<td>0.027</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>18.3 (54)</td>
<td>18.9 (27)</td>
<td>17.8 (27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separated or divorced</td>
<td>52.9 (156)</td>
<td>59.4 (85)</td>
<td>46.7 (71)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthplace of patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>76.7 (224)</td>
<td>7738 (109)</td>
<td>76.2 (115)</td>
<td>0.926</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>23.3 (68)</td>
<td>22.7 (32)</td>
<td>23.8 (36)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unfinished secondary</td>
<td>3.0 (9)</td>
<td>2.1 (3)</td>
<td>3.9 (60)</td>
<td>0.924</td>
<td></td>
</tr>
<tr>
<td>Spec. secondary</td>
<td>8.3 (25)</td>
<td>8.9 (130)</td>
<td>7.7 (12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>21.6 (65)</td>
<td>21.9 (32)</td>
<td>21.3 (33)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher</td>
<td>3.0 (9)</td>
<td>2.1 (3)</td>
<td>4.1 (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unfinished university</td>
<td>4.7 (14)</td>
<td>4.1 (6)</td>
<td>5.2 (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>59.5 (179)</td>
<td>61.0 (89)</td>
<td>58.1 (90)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No postsecondary</td>
<td>32.2 (95)</td>
<td>31.5 (45)</td>
<td>32.9 (50)</td>
<td>0.919</td>
<td></td>
</tr>
<tr>
<td>Some postsecondary</td>
<td>64.8 (200)</td>
<td>68.5 (98)</td>
<td>67.1 (102)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Believer (Yes)</td>
<td>88.5 (261)</td>
<td>93.7 (134)</td>
<td>83.6 (127)</td>
<td>0.006</td>
<td></td>
</tr>
<tr>
<td>Faith was of personal importance (Yes)</td>
<td>84.1 (248)</td>
<td>89.5 (128)</td>
<td>78.9 (120)</td>
<td>0.020</td>
<td></td>
</tr>
</tbody>
</table>

a values are given as percent for proportion (abs. number) or as appropriate
b median (interquartile range)
Statistical significance of the differences between the genders was calculated by Chi-square tests:
d t test
Figures 5.1 and 5.2 illustrate the distributions of the contents of delusions and hallucinations among patients with schizophrenia.

**Figure 5.1. Distribution of the content of delusions among patients with schizophrenia (N=295)**
Most unexpected finding of the research was delusions of infidelity which took the first highest place and comprised 81.3 %, followed by delusions of persecution, which took the second highest place and comprised 74.7%.
5.1. The impact of personal religiosity on presence and the content of religious delusions in patients with schizophrenia

From 295 respondents, there were 248 (84.1%) patients for whom their faith was of personal importance (Table 5.1). Male patients and female patients differently represented the personal importance of their faith, 89.5% of men and 78.9% of women reported their faith as for personal importance. ($\chi^2=6.1$ df=1 $p<0.05$).

Prevalence of religious delusions

The religious delusions were reported by 190 (64.4%) patients. There were not found a significant difference in the frequency of the development of religious delusions between male patients and female patients, 89 (62.2%) and 101 (66.4%) respectively ($\chi^2=0.57$ df=1 $p>0.05$).

![Figure 5.3. Distribution of patients with schizophrenia according to the content of their religious delusions](image)

However, there was significant difference was found in the content of religious delusions between men and women. The distribution of themes of the religious delusions in patients with schizophrenia according to sex is presented in Figure 5.3 ($\chi^2=70.03$ df=7 $p<0.001$). Most frequent theme of religious delusion in women was a belief that they were saint women, and most rare theme was that they were a God. In contrast to women, in men being a God was the most popular theme of delusions, and being a saint was a second popular theme.
**Determinants of the development of the religious delusions**

A significant but weak association has been found between the development of religious delusions and the personal importance of the faith ($\Phi=0.12 \ p<0.05$). Religious delusions were reported by 66.9% from those schizophrenia patients for whom their faith was of personal importance and by 51.1% from those schizophrenia patients for whom their faith was not of personal importance (gender and age adjusted OR=1.9; 95% CI, 1.1 to 3.6). However, there was no significant difference found in the occurrence of religious delusions separately in the male patients group and in the female patients groups regarding to the importance of their faith (Figure 5.4).

![Figure 5.4. The frequencies of religious delusions (%) in patients with schizophrenia according to the personal importance of their faith](image)

**In age and gender adjusted logistic regression analyses** (Table 5.2) four independent factors were significantly associated with the development of religious delusions: marital status, birthplace, education and personal importance of faith.

The divorced patients independently of the age and gender more frequently experienced religious delusions as compared to married patients (age and gender adjusted OR=2.2; 95% CI, 1.3 to 3.9).

Education was also associated with a frequency of the development of religious delusions (some postsecondary education vs. no postsecondary education OR=2.6; 95% CI, 1.5 to 4.3). Patients with rural birthplace demonstrated a lower risk of development of religious delusions (rural vs. urban OR=0.4; 95% CI, 0.3 to 0.8).
Table 5.2. Odds ratios and 95% confidence interval for development of religious delusions in relation to sociodemographic and clinical factors in patients with schizophrenia

<table>
<thead>
<tr>
<th>Factors</th>
<th>Percentage of patients&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Age and gender adjusted OR (95% CI)&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Age adjusted OR (95% CI)&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>All</td>
<td>Men</td>
</tr>
<tr>
<td>Age at onset:</td>
<td></td>
<td>p&lt;sub&gt;for trend&lt;/sub&gt;=0.34</td>
<td>p&lt;sub&gt;for trend&lt;/sub&gt;=0.31</td>
</tr>
<tr>
<td>Early onset ≤20 years&lt;sup&gt;#&lt;/sup&gt;</td>
<td>61.3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Middle and late onset (21 - &lt;60) years</td>
<td>65.2</td>
<td>1.2 (0.7-2.2)</td>
<td>2.0 (0.8-4.8)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td>p&lt;sub&gt;for trend&lt;/sub&gt;=0.001</td>
<td>p&lt;sub&gt;for trend&lt;/sub&gt;=0.001</td>
</tr>
<tr>
<td>Married&lt;sup&gt;#&lt;/sup&gt;</td>
<td>56.5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Single</td>
<td>48.1</td>
<td>0.7 (0.4-1.4)</td>
<td>1.5 (0.5-4.4)</td>
</tr>
<tr>
<td>Separated or divorced</td>
<td>74.4</td>
<td>2.2 (1.3-3.9)**</td>
<td>2.4 (1.1-5.7)**</td>
</tr>
<tr>
<td>Birthplace of patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban&lt;sup&gt;#&lt;/sup&gt;</td>
<td>69.2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rural</td>
<td>50.0</td>
<td>0.4 (0.3-0.8)**</td>
<td>0.3 (0.1-0.6)**</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No postsecondary&lt;sup&gt;#&lt;/sup&gt;</td>
<td>49.5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Some postsecondary</td>
<td>71.5</td>
<td>2.6 (1.5-4.3)**</td>
<td>2.6 (1.2-5.3)**</td>
</tr>
<tr>
<td>Religious</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No&lt;sup&gt;#&lt;/sup&gt;</td>
<td>64.7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Yes</td>
<td>64.4</td>
<td>0.98 (0.5-2.1)</td>
<td>0.8 (0.2-3.4)</td>
</tr>
<tr>
<td>Faith was of personal importance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No&lt;sup&gt;#&lt;/sup&gt;</td>
<td>51.1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Yes</td>
<td>66.9</td>
<td>1.9 (1.08-3.6)&lt;sup&gt;*&lt;/sup&gt;</td>
<td>2.8 (0.9-8.4)</td>
</tr>
</tbody>
</table>

<sup>a</sup> percentage of patients with the religious delusions
<sup>b</sup> OR, odds ratio; CI, confidence interval; odds ratio was statistically significant when 1 was not included into its 95% confidence interval
<sup>#</sup> reference category
<sup>*</sup> p<0.05; ** p<0.01; *** p<0.001

Multivariate logistic regression analysis was employed for evaluation of the impact of sociodemographic and clinic factors on development of religious delusions (Table 5.3). Marital status (divorced/separated vs. married OR=2.0; 95% CI, 1.1 to 3.5) and education (some postsecondary education vs. no postsecondary education OR=2.3; 95% CI, 1.4 to 3.9) significantly predicted religious content of delusions.
Table 5.3. Factors related to the development of religious delusions in patients with schizophrenia (adjusted for gender, age, age at onset, birthplace, education, personal importance of the faith)

<table>
<thead>
<tr>
<th>Factors</th>
<th>Number of subjects</th>
<th>Multivariate-adjusted&lt;sup&gt;a&lt;/sup&gt; OR (95% CI)&lt;sup&gt;b&lt;/sup&gt;</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married&lt;sup&gt;#&lt;/sup&gt;</td>
<td>85</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>54</td>
<td>0.7 (0.4-0.5)</td>
<td>0.385</td>
</tr>
<tr>
<td>Separated or divorced</td>
<td>156</td>
<td>2.0 (1.1-3.5)</td>
<td>0.019</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No postsecondary&lt;sup&gt;#&lt;/sup&gt;</td>
<td>95</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Some postsecondary</td>
<td>200</td>
<td>2.3 (1.4-3.9)</td>
<td>0.002</td>
</tr>
</tbody>
</table>

Model Nagelkerke $R^2=0.12$

<sup>a</sup> adjusted for age, sex, age-onset, marital status, birthplace, education, personal importance of the faith

<sup>b</sup> OR, odds ratio; CI, confidence interval; odds ratio was statistically significant when 1 was not included into its 95% confidence interval

# reference category

In conclusion, after multivariate adjustment for important co-variables, the personal importance of the faith was not found as associated with development of religious delusions among patients with schizophrenia.

5.2. The impact of personal religiosity on presence and the content of the world end delusions in patients with schizophrenia

From 295 patients with schizophrenia 206 (69.8%) answered “Yes” to the question “Did you feel the world had come to an end or would soon come to an end?” There was no significant differences in the frequency of the development of the end of the world (apocalyptic) delusions between men and women – 101 (70.6%) and 105 (69.1%) respectively ($\chi^2=1.1$ df=1 p>0.05).

A significant relationship was found between the development of the end of the world delusions and the personal importance of the faith (Phi=0.33 p<0.001). The upcoming end of the world was 6 times more frequently perceived by those schizophrenia patients for whom their faith was of personal importance compared to those for whom it was not (gender and age adjusted OR=6.0 95% CI 3.1 to 11.9).
Figure 5.5. Distribution of the world end (apocalyptic) delusions (%) in patients with schizophrenia according to the personal importance of their faith

The upcoming end of the world was felt by as many as 75.8% (73.4% among men and 79.2% among women) of those for whom their faith was of personal importance and only 36.2% (46.7% and 31.3%) of those schizophrenia patients for whom their faith was not of personal importance (Figure 5.5).

Figure 5.6. Distribution of the world end (apocalyptic) delusions (%) in patients with schizophrenia according to marital status

The analysis showed that the marital status was related (Phi=-0.25 p<0.001) to the development of the world end delusions (Figure 5.6). There was found that divorced patients independently of the age and gender more frequently experienced delusions of the end of the world compared to married patients (sex and age adjusted OR=3.3 95% CI 1.8 to 5.9).

No significant differences were found concerning the frequencies of the development of delusions of the end of the world according to the education, to the birthplace, to the age-onset. However, these potential confounding variables, and marital status and presence of the personal importance of faith were entered into the forward stepwise logistic regression models with presence
of delusions as the dependent variable. Overall, this analysis shows that, being divorced/separated and having the personal importance of faith independently increased the frequency of the end of the world delusions (Table 5.4).

Table 5.4. Factors related to the development of the world end delusions in patients with schizophrenia (adjusted for gender, age, age-onset, birthplace, education, personal importance of the faith)

<table>
<thead>
<tr>
<th>Factors</th>
<th>Number of subjects</th>
<th>Multivariate-adjusteda OR (95% CI)b</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faith was of personal importance, (1 - No; 2 – Yes)</td>
<td>278</td>
<td>5.7 (2.9-10.9)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married#</td>
<td>85</td>
<td>1</td>
<td>p_trend 0.002</td>
</tr>
<tr>
<td>Single</td>
<td>54</td>
<td>1.1 (0.5-2.3)</td>
<td>0.781</td>
</tr>
<tr>
<td>Separated or divorced</td>
<td>156</td>
<td>2.7 (1.5-4.9)</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Model Nagelkerke $R^2=0.179$

a adjusted for age, sex, age-onset, marital status, birthplace, education, personal importance of the faith

b OR, odds ratio; CI, confidence interval; odds ratio was statistically significant when 1 was not included into its 95% confidence interval

# reference category

The distribution of the theme of delusions of apocalypse in patients with schizophrenia according to importance their faith is presented in Figure 5.7. One–third (32.3%) of patients who stated their faith as of personal importance indicated that they experienced apocalyptic delusions of religious content (only 2.1% among those for whom the faith was not of personal importance).

![Figure 5.7. Distribution of the themes of the world end (apocalyptic) delusions (%) in patients with schizophrenia according to the personal importance of their faith](image)

$\chi^2=13.5 df=2 p=0.001$

53
The association of the theme of apocalypse with gender was significant. The distribution of the theme of delusions of apocalypse (%) in patients with schizophrenia according to gender is presented in Figure 5.8 ($\chi^2=10.3$ df=3 $p<0.05$). The female patients experienced more delusions with religious content as compared to men (32.2% and 22.4% respectively). More patients who experienced apocalyptic delusions with global content were found among male patients as compared to female patients (30.1% and 15.1% respectively).

![Figure 5.8. Distribution of the theme of delusions of apocalypse (%) in patients with schizophrenia according to gender](image)

In conclusion, this analysis demonstrates that, being divorced/separated and having the personal importance of faith independently increased the frequency of the end of the world delusions.

5.3. The impact of personal religiosity on presence and content of visual hallucinations in patients with schizophrenia

39.1% of respondents reported visual hallucinations. Socio-demographic characteristics of 295 surveyed patients with schizophrenia are presented in Table 5.1. Male and female patients were similar with respect to age, birthplace, duration of illness, age at illness onset, and education. There was a significant difference in the patients’ distribution in marital status groups according to gender. Male patients were more likely to be divorced/separated than women.

The average of age among male and female patients, at the onset of the illness was equivalent: male – 24.8 (SD 4.4), median=25 (interquartile range 5); females – 24.8 (SD 5.2), median=25 (7). No statistically significant difference between genders was identified by age in the target groups at
onset of illness (early, medium and late onset of illness). About three-fourths of examinees (80.1 percent – men, 71.6% - women) at the onset of the illness were from 21 to 35 years old. About one quarter of women (24.5 percent) and 18.5 percent of men developed the disease at the age until 20.

Figure 5.9. Distribution of visual hallucination among patients with schizophrenia by gender

Visual hallucinations were reported by 39.1% of patients and the frequency of presence of this type of hallucinations did not differ significantly among men and women (men – 34.7%; women – 43.2%; $\chi^2=2.27$ df=1 p=0.132) (Figure 5.9).

Figure 5.10. Distribution of visual hallucinations according to the age at the onset of illness

When analysing visual hallucinations, no relationships was established with a patient’s age (Pearson’s $r=0.075$ p>0.05), gender ($\chi^2=2.27$ df=1 p=0.132), marital status ($\chi^2=5.5$ df=2 p=0.065) and other socio-demographic indices, however the development of visual hallucinations was associated with the age of patients at the onset of the illness (Spearman’s $r=0.13$ p<0.05). A stronger correlation was established with this variable which is divided into three categories – Spearman’s $r=0.18$ (p<0.01). Visual hallucinations were developed in 58.5% of those patients whose illness started at the age until 20, and only in one-third (33.2%) of the patients whose illness started later – at the age of 21 to 35 years ($\chi^2=15.4$ df=2 p<0.001), (Figure 5.10).
The majority of the patients reported that they had faith – 263 (87.4%). Association were established between gender, faith and personal importance of faith. Significantly more men than women reported having faith: 91.8% and 83.2% respectively ($\chi^2=5.0$ df=1 $p<0.05$). Significantly more men (89.5%) than women (78.9%) admitted personal importance of faith ($\chi^2=6.2$ df=1 $p<0.05$).

Figure 5.11. Distribution of visual hallucinations according personal importance of faith among patients with schizophrenia by gender

The relationship was established between visual hallucinations and personal importance of the faith. 42.7% of patients whose faith was of personal importance for them reported visual hallucinations, however among those patients who reported their faith was not of personal importance was twice less – 21.3% ($\chi^2=7.5$ df=1 $p<0.01$) (Figure 5.11).

No significant relationship between development of visual hallucinations and personal importance of faith was identified in examined male patients (36.5% and 26.7% respectively; $\chi^2=5.5$ df=1 $p>0.05$). Female patients, however, for whom their faith was of personal importance, reported visual hallucinations more frequently than females, for whom it was not (49.2% and 18.8% respectively; $\chi^2=7.6$ df=1 $p<0.01$).
Table 5.5. Odds ratios and 95% confidence interval for development of visual hallucinations in relation to sociodemographic and clinical factors (univariate logistic regression analysis)

<table>
<thead>
<tr>
<th>Factor</th>
<th>OR (95% CI)²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (women vs. men)</td>
<td>1.4 (0.8-2.2)</td>
<td>0.201</td>
</tr>
<tr>
<td>Age, year</td>
<td>1.0 (0.97-1.02)</td>
<td>0.885</td>
</tr>
<tr>
<td>Duration of schizophrenia, years</td>
<td>1.01 (0.9-1.04)</td>
<td>0.245</td>
</tr>
<tr>
<td>Age at onset of illness, years</td>
<td>0.95 (0.89-0.99)</td>
<td>0.045</td>
</tr>
<tr>
<td><strong>Age at onset of illness:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early ≤20 years</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Medium (21 - &lt;35) years</td>
<td>0.33 (0.2-0.6)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Late (35 - &lt;60) years</td>
<td>0.90 (0.2-4.4)</td>
<td>0.897</td>
</tr>
<tr>
<td><strong>Marital status:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2.3 (1.1-4.7)</td>
<td>0.020</td>
</tr>
<tr>
<td>Divorced</td>
<td>1.5 (0.8-2.6)</td>
<td>0.179</td>
</tr>
<tr>
<td><strong>Origin:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>1.1 (0.7-1.9)</td>
<td>0.655</td>
</tr>
<tr>
<td>Rural</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unfinished secondary</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Spec. secondary</td>
<td>0.3 (0.03-2.1)</td>
<td>0.199</td>
</tr>
<tr>
<td>Secondary</td>
<td>1.1 (0.4-2.5)</td>
<td>0.914</td>
</tr>
<tr>
<td>Higher</td>
<td>1.7 (0.9-3.0)</td>
<td>0.075</td>
</tr>
<tr>
<td>Unfinished university</td>
<td>1.4 (0.4-5.4)</td>
<td>0.625</td>
</tr>
<tr>
<td>University</td>
<td>1.5 (0.5-4.6)</td>
<td>0.483</td>
</tr>
<tr>
<td><strong>Believer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2.7 (1.1-6.6)</td>
<td>0.022</td>
</tr>
<tr>
<td><strong>Personally important faith</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2.7 (1.3-5.7)</td>
<td>0.007</td>
</tr>
</tbody>
</table>

² OR, odds ratio was statistically significant when 1 was not included into its 95% confidence interval

# reference category

b change of probability corresponds to the change of an indicator per year

The table 5.5 shows the results of the univariate logistic regression analyses, with the odds ratios allowing for the quantitative evaluation of the relationship of sociodemographic and clinic factors with development of visual hallucination. Every subsequent (later) year of the age-onset of illness reduced by 5 percent the probability to experience visual hallucinations (OR=0.95; 95% CI 0.89 to 0.99). In respect of early onset of illness (≤20 years) 67% less probability (OR=0.33; 95% CI 0.19 to 0.59) to experience visual hallucinations was in patients whose illness started at medium age (21 to 35 years) and 10% less (but statistically insignificant) probability was in patients whose onset of illness was late (between 35 and 60 years). Single patients 2.3 times (OR=2.3; 95% CI 1.1 to 4.7) more often reported experiencing visual hallucinations than married patients. About three times higher probability to experience visual hallucinations was identified in believers as compared
to non-believers (OR= 2.7; 95% CI 1.1 to 6.6) and in those whose faith was personally important for them (OR=2.7; 95% CI 1.3 to 5.7).

The factors statistically significant associated with the development of hallucinations in univariate analysis were selected as candidates to the prognostic factors of development of visual hallucinations. The results of multivariate regression analysis are given in Table 5.6.

Table 5.6. The prognostic factors related to the development of visual hallucinations

<table>
<thead>
<tr>
<th>Factors</th>
<th>Multivariate-adjusted&lt;sup&gt;a&lt;/sup&gt; OR (95% CI)&lt;sup&gt;b&lt;/sup&gt;</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at the onset of the illness:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early ≤20 years&lt;sup&gt;#&lt;/sup&gt;</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Medium (21 - &lt;35) years</td>
<td>0.33 (0.18-0.59)</td>
<td>0.000</td>
</tr>
<tr>
<td>Late (35 - &lt;60) years</td>
<td>1.05 (0.21-5.36)</td>
<td>0.953</td>
</tr>
<tr>
<td>Personal importance of faith (Yes versus No)</td>
<td>2.92 (1.36-6.28)</td>
<td>0.006</td>
</tr>
</tbody>
</table>

Model’s Nagelkerke $R^2$=0.11

<sup>a</sup> adjusted for age, sex, age-onset, marital status, education, personal importance of the faith

<sup>b</sup> OR, odds ratio; CI, confidence interval; odds ratio was statistically significant when 1 was not included into its 95% confidence interval

<sup>#</sup> reference category

The multiple logistic regression analysis, upon inclusion into the model of the factors associated with the development of visual hallucinations in univariate analysis (age, gender, age at the onset of the illness, personal importance of faith, marital status and education) and having a regard to its confounding effect, has proved that the early onset of the illness (until 21 vs. medium age-onset 21 to 35) and personal importance of faith (OR=2.9; 95% CI 1.4 to 6.3) were independent factors for the development of visual hallucinations.

In conclusion, personal importance of the faith was independent predictor for development of visual hallucinations in patients with schizophrenia.
5.4. The impact of culture on psychotic symptoms in schizophrenia

Characteristics of the international multicentre study of the participants by gender are presented in Table 4.1. Of 1080 patients were selected 73 patients from each country (N=511), and were performed discriminant analyses separately for three psychotic symptoms in schizophrenia group (contents of delusions, hallucinations and Schneider’s FRS) in order to estimate the impact of culture on the prevalence of the delusions, hallucinations and FRS.

Independent of culture, persecution was the most common delusional theme in all sites followed by grandeur. Pakistan, the only pure Islamic country, showed a pattern of delusional contents remarkably different from the other sites with Christian majorities: low rates of religious delusions, delusions of grandeur and delusions of guilt. Religious delusions occurred only as persecution by demons or obsession by Djins. In contrast to the African countries religious grandiosity (‘Being and Angel or a Prophet’ etc.) was not reported by Pakistani patients.

Statistically significant differences (Chi-Square-Test) in the frequencies of several kinds of hallucinations were found in this study. The prevalence of visual hallucinations in the developing countries was inhomogeneous. As to be expected, in every country auditory hallucinations showed the highest prevalence. Visual hallucinations were most frequently reported by West-African patients (Nigeria, 45.8%; Ghana, 53.9%), the rate for Pakistanis was only 3.9%. As mentioned above the distinction ‘developing’ and ‘developed’ countries seems not to be meaningful. To explain these different rates one has to separately scrutinize the cultural tradition and the socialization pattern of each country.

At least one FRS across the regions was registered between 100% (Nigeria), 97.3% (Georgia), 96.3% (Poland), 90.4% (Lithuania), 90.3% (Austria), 83.5% (Pakistan), and 81.6% (Ghana). The frequency of the single FRS varied remarkably in the different sub-samples. Those FRS associated with disturbances of the ego-boundaries (audible thoughts, thought broadcast, and thought insertion) most frequently occur in both West-African countries. The acoustic first rank hallucinations were also most common in Nigeria and in Ghana; however, they were also very often reported in Poland and in Georgia. Somatic passivity was most frequent in Poland and in Lithuania.

The proportion of the variance of psychotic phenomena which cannot be correctly assigned to the country of origin of patients (culture-unspecific) is between 60 and 70% (Figure 5.12). Therefore the proportion of correctly classified cases is between 30 and 40%. This percentage is the upper border of the possible influence of culture. However, the likelihood to classify correctly by chance in our sample is 14.3 % (100:7 countries). This percentage has to be seen as a kind of “gray zone”, i.e., in 14.3% it cannot be definitely excluded that the ‘correct’ assignment has been achieved by chance.
Figure 5.12. Estimated influence of culture on psychotic symptoms in schizophrenia

So taking this into account, the average correct assignment of psychotic phenomena to countries of origin is between 16 and 40%. Only Pakistan had a special position with correct classifications between 20 and 60%.

Between 15% and 30% of the frequencies of contents of delusions, modalities of hallucinations and first rank symptoms may be caused by differences in the cultures of origin. In contrast between 70% and 85% of the variance of the prevalence of psychotic symptoms does not depend on the culture of origin.

In conclusion, results confirm cultural psychiatry as an important tool for the understanding and consequently for the treatment of patients with major mental disorders. There are two ways to interpret our findings: (a) It can be assumed that 15-30 percent of the psychotic symptomatology is culture-dependent, (b) This percentage represents only a cross-sectional snapshot, reproducing the present cultural distances of the countries included in our study.
5.5. The specificity of paranoid-hallucinatory syndromes in schizophrenia in different cultures

Principal component analysis (PCA) with Varimax rotation was performed to re-examine previous results concerning the existence of stable, characteristic and distinguishable paranoid-hallucinatory syndromes by means of PCA and to investigate possible differences in the distribution of these syndromes in patients with schizophrenia from different countries.

Table 5.7 shows the rotated solution of the principal component analysis. PCA resulted in 7 interpretable factors accounted for 59.8% of the total variance.

**Table 5.7. Paranoid-hallucinatory syndromes in schizophrenia**
(Principal component analysis, Varimax rotation)

<table>
<thead>
<tr>
<th>Factor loading</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
<th>Factor 5</th>
<th>Factor 6</th>
<th>Factor 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variance accounted (%)</td>
<td>11.4%</td>
<td>9.8%</td>
<td>8.8%</td>
<td>8.0%</td>
<td>7.7%</td>
<td>7.6%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Delusions of grandeur</td>
<td>0.78</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious delusions</td>
<td>0.71</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delusions of descent</td>
<td>0.51</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olfactory hallucinations</td>
<td></td>
<td>0.84</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gustatory hallucinations</td>
<td></td>
<td>0.72</td>
<td>0.42</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tactile hallucinations</td>
<td></td>
<td>0.51</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypochondriac delusions</td>
<td></td>
<td></td>
<td>0.77</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coenesthetic hallucinations</td>
<td></td>
<td></td>
<td>0.74</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auditory hallucinations</td>
<td></td>
<td></td>
<td></td>
<td>0.76</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual hallucinations</td>
<td></td>
<td>0.54</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delusions of persecution</td>
<td></td>
<td></td>
<td></td>
<td>0.47</td>
<td>0.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delusions of guilt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delusions of apocalypse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.63</td>
<td></td>
</tr>
<tr>
<td>Delusions of being loved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.41</td>
</tr>
<tr>
<td>Delusions of being poisoned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.71</td>
<td></td>
</tr>
<tr>
<td>Delusions of jealousy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.84</td>
</tr>
</tbody>
</table>

Note: N = 511. Extraction: Principal component analysis with varimax rotation. Loadings < .4 are not showed for clarity. Bold indicates primary symptom loadings for each factor.

The first factor (accounted for 11.4% of the variance) has high loadings from delusions of grandeur and descent, religious delusions and visual hallucinations. The second factor (9.8%) is strongly associated with gustatory, olfactory and tactile hallucinations. The third factor (8.8%) is strongly associated with hypochondriac delusions and coenesthetic hallucinations, the fourth factor
with auditory hallucinations and persecutory delusions. The fifth factor \((7.7\%)\) is bipolar consisting only of delusions: it is positively associated with delusions of guilt and apocalypse, and negatively associated delusions of being loved. The sixth \((7.6\%)\) factor is associated with delusions of being poisoned, being persecuted and delusions of descent as well as with gustatory hallucinations. Finally, factor seven \((6.5\%)\), consists only of delusions of jealousy.

We named factor 1 “religious grandiosity syndrome”, factor 2 - “low perception syndrome”, factor 3 – “coenesthetic hypochondria syndrome”, factor 4 – “apocalyptic guilt syndrome”, factor 5 – “persecutory syndrome”, factor 6 – “poisoning syndrome”, and factor 7 – “delusional jealousy”.

For further analyses the standardized factor score were saved as regression coefficients (values between +1 and -1). To test the differences of the mean values between the samples of the single country, One-Way ANOVA with Tukey post hoc tests were performed. With the exception of delusional jealousy all other paranoid-hallucinatory syndromes were unequally distributed between the seven countries (Table 5.8).

### Table 5.8. Paranoid hallucinatory syndromes in schizophrenia by country

<table>
<thead>
<tr>
<th>Country</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
<th>Factor 5</th>
<th>Factor 6</th>
<th>Factor 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>0.1 ± 1.0</td>
<td>0.1 ± 1.1</td>
<td>0.3 ± 1.1</td>
<td>-0.3 ± 1.1</td>
<td>-0.1 ± 1.1</td>
<td>-0.3 ± 0.8</td>
<td>-0.1 ± 0.9</td>
</tr>
<tr>
<td>Poland</td>
<td>0.0 ± 1.1</td>
<td>0.0 ± 1.0</td>
<td>0.2 ± 1.1</td>
<td>0.0 ± 1.1</td>
<td>0.2 ± 1.1</td>
<td>0.0 ± 0.7</td>
<td>-0.1 ± 0.8</td>
</tr>
<tr>
<td>Lithuania</td>
<td>-0.1 ± 1.0</td>
<td>0.2 ± 1.3</td>
<td>0.1 ± 1.3</td>
<td>0.2 ± 1.1</td>
<td>0.1 ± 0.7</td>
<td>0.2 ± 1.0</td>
<td>0.2 ± 1.3</td>
</tr>
<tr>
<td>Georgia</td>
<td>0.0 ± 0.9</td>
<td>0.2 ± 1.0</td>
<td>0.2 ± 1.0</td>
<td>-0.3 ± 0.7</td>
<td>-0.4 ± 1.4</td>
<td>0.2 ± 1.3</td>
<td>-0.1 ± 1.3</td>
</tr>
<tr>
<td>Pakistan</td>
<td>-0.7 ± 0.6</td>
<td>-0.3±0.3</td>
<td>-0.3 ± 0.3</td>
<td>-0.3 ± 0.4</td>
<td>-0.2 ± 0.6</td>
<td>-0.2 ± 0.7</td>
<td>0.1 ± 0.8</td>
</tr>
<tr>
<td>Nigeria</td>
<td>0.2 ± 1.0</td>
<td>0.1 ± 1.3</td>
<td>0.1 ± 1.3</td>
<td>0.0 ± 0.9</td>
<td>0.0 ± 1.1</td>
<td>-0.2 ± 1.0</td>
<td>0.3 ± 0.8</td>
</tr>
<tr>
<td>Ghana</td>
<td>0.4 ± 0.8</td>
<td>-0.2 ± 0.6</td>
<td>-0.2 ± 0.6</td>
<td>-0.1 ± 0.9</td>
<td>0.4 ± 0.8</td>
<td>0.3 ± 1.0</td>
<td>0.0 ± 0.8</td>
</tr>
</tbody>
</table>

| P         | <0.001   | <0.05    | <0.001   | <0.001   | <0.001   | <0.01    | n.s.     |

*Statistically significant differences by means of Tukey-test:

1 Factor 1, Pakistan - lower mean vs. all others countries
2 Factor 2, Pakistan - lower mean vs. Georgia
3 Factor 3, Austria - higher mean vs. Pakistan, Nigeria, Georgia
4 Factor 3, Pakistan - lower mean vs. Ghana
5 Factor 4, Lithuania - higher mean vs. all others countries
6 Factor 5, Georgia - lower mean vs. Lithuania, Poland
7 Factor 5, Ghana - higher mean vs. Austria, Pakistan
8 Factor 6, Austria - lower mean vs. Lithuania, Ghana, Georgia

Several statistically significant differences were found by means of Tukey-test: lower mean values concerning the “religious grandiosity syndrome” in the Pakistani group compared with all
the other sites, lower mean values for the “low perception syndrome” in Pakistanis compared with the Georgian subjects, higher mean values for the “coenesthetic hypochondria syndrome” in Austria compared with Pakistan, Nigeria, and Georgia, and lower mean values of for the “coenesthetic hypochondria syndrome” in Pakistan compared with Ghana. Lithuanian patients showed higher mean values in the “apocalyptic guilt syndrome” than patients of all other sites. A more complex situation was found with the “persecutory syndrome”: higher mean values in Ghana compared with Austria and Pakistan and lower mean values in Georgia compared with Lithuania and Poland. The “poisoning syndrome” showed lower mean values in Austria compared with Lithuania, Ghana and Georgia.

In conclusion, there were found: (1) seven distinguishable syndromes - “religious grandiosity syndrome”, “low perception syndrome”, “coenesthetic hypochondria syndrome”, “apocalyptic guilt syndrome”, “persecutory syndrome”, “poisoning syndrome”, and “delusional jealousy” and (2) in fact statistically significant differences in six of seven syndromes pointing to a marked impact of culture on the characteristics of psychotic phenomenology.

5.6. The prevalence of delusions of guilt in Catholic patients with schizophrenia compared with delusions of guilt of Muslims patients with schizophrenia

Figure 5.13 shows the one-year prevalence of delusions of guilt in schizophrenia in 1006 subjects: Austria (n = 350), Poland (n = 80), Lithuania (n = 73), Pakistan (n = 103), Nigeria (n = 324), and Ghana (n = 76).
Neither sex nor ages was found to influence delusions of guilt. Pakistani patients reported a low percentage (1.0%) of delusions of guilt compared with Polish (18.8%) and Lithuanian (24.7%) subjects, followed by similar percentages in African and Austrian patients.

When considering the differences between the three developing non-European countries, one must keep in mind that nearly 60% of the patients from Nigeria and 84% from Ghana are Christians (Figure 5.14)

![Figure 5.14. Distribution of patients with schizophrenia from Austria, Poland, Lithuania, Pakistan, Nigeria, and Ghana according to religious confession](image)

Before comparing the prevalence of delusions of guilt in patients from Christian and Muslim backgrounds, as well as those who do not adhere to any religious tradition it was determined whether patients with the same confession coming from very different cultures were homogenous.

<table>
<thead>
<tr>
<th>Religious confession</th>
<th>Austria (N = 350)</th>
<th>Poland (N = 80)</th>
<th>Lithuania (N = 73)</th>
<th>Pakistan (N = 103)</th>
<th>Nigeria (N = 324)</th>
<th>Ghana (N = 76)</th>
<th>Sign*</th>
</tr>
</thead>
<tbody>
<tr>
<td>No confession</td>
<td>67</td>
<td>7</td>
<td>12</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Delusions of guilt</td>
<td>3 (4.5%)</td>
<td>7 (14.2%)</td>
<td>0</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Muslims</td>
<td>—</td>
<td>—</td>
<td>103</td>
<td>127</td>
<td>10</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Delusions of guilt</td>
<td>—</td>
<td>—</td>
<td>1 (1%)</td>
<td>7 (5.8%)</td>
<td>1 (10.0%)</td>
<td>&gt;0.05</td>
<td></td>
</tr>
<tr>
<td>Protestants</td>
<td>17</td>
<td>—</td>
<td>7</td>
<td>65</td>
<td>16</td>
<td>—</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Delusions of guilt</td>
<td>7 (6.2%)</td>
<td>0</td>
<td>—</td>
<td>7 (12.1%)</td>
<td>0</td>
<td>7 (12.0%)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Catholics</td>
<td>266</td>
<td>73</td>
<td>54</td>
<td>132</td>
<td>50</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Delusions of guilt</td>
<td>36 (13.5%)</td>
<td>14 (19.2%)</td>
<td>18 (33.3%)</td>
<td>20 (15.2%)</td>
<td>6 (12.0%)</td>
<td>—</td>
<td></td>
</tr>
</tbody>
</table>

* Chi-Square Test
Although Table 5.9 illustrates that Muslim patients from Pakistan show less delusions of guilt than those from Nigeria and Ghana, the differences did not reach the 5% significance level. The same holds true for Protestants from Austria, Lithuania, Nigeria, and Ghana. However, the Catholic group displayed statistically significant differences caused by the high number of Lithuanians with delusions of guilt.

Religious groups were considered to be homogenous enough to be compared statistically. A strong but ambiguous association between delusions of guilt and religious confession became obvious (Figure 5.15).

Patients with a Christian background reported a higher prevalence of delusions of guilt; 16.3% Roman-Catholics and 7.3% Protestants as compared with their Muslim counterparts (3.8%). But even those European patients who consider themselves as non-religious (4.7%) showed delusional guilt more often than the Muslim group.

![Figure 5.15. Frequency of delusions of guilt (%) among patients with schizophrenia according to confession](image)

Further information concerning the impact of religious confession on delusions of guilt emerged from the analysis of self-accusing patients. Delusional guilt can appear in four different themes. Table 5.10 illustrates that negative delusional identities and ontological guilt are only found in Christian patients. The majority of the few Muslim patients with delusions of guilt report that they have failed to do their prayers or they have neglected their duties toward their relatives.
Table 5.10. Themes of delusions of guilt and confession of patients with schizophrenia reporting delusional guilt (N = 115)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Roman-Catholics (n = 94)</th>
<th>Protestants (n = 8)</th>
<th>Muslims (n = 9)</th>
<th>No confession (n = 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative delusional identity</td>
<td>8 (8.5%)</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Ontological guilt</td>
<td>12 (12.7%)</td>
<td>2 (25.0%)</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Guilt of action</td>
<td>50 (53.2%)</td>
<td>6 (75.0%)</td>
<td>3 (33.3%)</td>
<td>4 (100%)</td>
</tr>
<tr>
<td>Guilt of omission</td>
<td>29 (30.9%)</td>
<td>2 (25.0%)</td>
<td>7 (77.8%)</td>
<td>—</td>
</tr>
</tbody>
</table>

In conclusion, delusions of guilt are a complex phenomenon expressed under the influence of diverse cultural patterns (Figure 5.13). According to this study, since an association between delusions of guilt and religious tradition (Figure 5.15) seemed to exist independent of culture (Table 5.9), it is worth examining the concepts of "Good and Evil" in Christianity and Islam.
6. DISCUSSION

6.1. The impact of personal religiosity on presence and the content of religious delusions in patients with schizophrenia

Results of our study have demonstrated that religiosity in general as well as personal importance of the faith are not directly related to the religious content of delusions in patients with schizophrenia and are associated with education and family status of the patient. Content of religious delusions is gender specific. Among women prevailed a theme of being as saints, whereas among men prevailed a theme of being a God.

In our research religious delusions appeared in the fifth place (63.3%), following the most unexpected finding, delusions of infidelity (81.3%) on top among the all contents of delusions, leaving delusions of persecution in the second place (74.7%), then followed by grandeur delusions (74%), and apocalyptic delusions (68.8%)

The affinity of schizophrenia to religion was recognized and was a topic for intense research already in 19th century [Stompe et al., 1999]. German psychiatrist Spitzer claims that clinically religious delusions can only be diagnosed indirectly. Indirect signs of delusions are the incidence of other symptoms of mental disease, inconsistencies between utterances and behavior, constriction or torpor of thinking, feeling and acting [Stompe et al., 1999; Spitzer, 1989]. Studies of religious delusions and hallucinations with religious content are of interest because these symptoms may lead to violent behavior [Kraya & Patrix, 1997]. The prevalence of delusions and hallucinations with religious content varies between cultures and over time [Ndetei & Vadher, 1984b]. Religious practices have been associated with a higher rate of religious delusions [Peters et al., 1999], but personal religiosity is not necessary for the development of religious delusions. A number of studies have reported large differences in the prevalence of religious delusions around the world [Bhavsar & Bhugra, 2008]. Despite evidence for the clinical significance of religious delusions, models aimed at explaining the epidemiological differences, and integrating religious factors in to the formation of delusions, have been lacking [Bhavsar & Bhugra, 2008].

Stompe and colleagues (1999) found that, that neither in Pakistan nor in Austria any connection was established between contents of delusions and social status as well as level of education of patients with schizophrenia [Stompe et al., 1999]. A study of mental health status of immigrant farm workers in the United States has discovered higher acculturative stress and higher anxiety levels in immigrants who reported lower religiosity and higher education [Hovey & Magana, 2002]. However, this study was not related to psychotic population. Religious delusions have been reported with varying prevalence from cultures around the world. There is considerable
evidence in the literature to indicate that the presentations of psychosis varie across cultures. A key remit of cultural psychiatry is to explain and quantify these differences [Bhavsar and Bhugra, 2008].

Our findings of lack of relationship between religiosity of the patients and religious content of delusions are in line with reports of other authors [Tadeshei, 1957; Tateyama et al., 1993; Stompe et al., 1999; Stompe et al., 2001; Stompe et al. 2002; Stompe et al., 2006]. Former studies have demonstrated that religious delusions are most frequent in catholic societies followed by protestant and Islamic ones; in Buddhist countries it is considered as rare content of delusion [Goldwert, 1990; Stompe et al., 2006; Ng, 2007]. Kimura (1995) suggests that this fact is due to structural differences between these various religious [Kimura, 1995]. Stompe and colleagues (1999) found that religious delusional ideas are more frequent in Austrian than in Pakistani patients (21.3% vs. 5.6%, p<0.001) [Stompe et al., 1999].

Dissociation between religiosity and content of delusions may be explained by several possible mechanisms. Firstly this dissociation may reflect the schizophrenic distortion between reality and content of psychopathology [Wilson, 1998; Varma, 2000]. Siddle found that a fifth of patients with religious delusions admitted to a Manchester in –patient unit with psychosis had religious delusions in the absence of a religious background [Siddle et al, 2002]. Religion is an enduring theme in psychosis, the understanding of which can be assisted by distinguishing between religion as a culture and religiosity as pathology [Ng, 2007]. Fractured ego in Reactive Schizophrenia can range far and wide in building religious systems which, though bizarre, are often impressive in their complexity [Goldwert, 1990]. On the other hand faith and religious practices may preserve this domain from psychopathology. Importance of cultural background on the content of delusions was demonstrated by several studies [Thara & Eaton, 1996; Peters et al., 1999].

We found that religious delusions were more frequently reported by divorced and separated patients, and in those respondents who had better education. Kumar described likely parallel note about Indian patients, stating that religious delusions were more frequent in unmarried patients [Kumar, 1984]. Divorce and separation most often bring pain and crisis in personal life and urges searching for coping mechanisms. Religion could be one of these mechanisms [Cow, 1986; Kaplan et al., 1994]. In psychotic patients these mechanisms may be reflected by religious themes in their psychopathology, as relief from subconscious mind and seeking for solace? [Stompe et al., 2001]. In psychological aspect, religion is defined as response to unexpected situations. Others describe religion as the essence of the mode of life and see in religion the expression of human perfection [Tseng, 2001]. Science of Theology provides with guidance for hope and teaching to cope. “And God shall wipe away all tears from their eyes; and there shall be no more death, neither sorrow, nor crying, neither shall there be any more pain: for the former things are passed away” [Rev. 21.1-5a]. Jesus’ words “I give you a new commandment – love one another”, conveyed by disciple John,
carry a psychotherapeutic sense (Jn 13.31-33a, 34-35) [Sacred Scripture, 1990; Kataliku Baznycios katekizmas, 1997; The New Testament, 2006].

The finding that higher education is related with religious content of delusions suggests that these themes are not primitive or infant as it is considered in psychoanalyses [Freud, 1911; Varma, 1999; Tseng, 2001] and by some other authors [Bartocci, 2006]. Contrary, it is reasonable to consider that higher education is a marker of better preserved personality, better cognitive functioning and more favorable course of the mental disease. Religious content of delusions, such as being a God or being as Saint, is related with grandiosity and affective component of the psychoses [Peters et al., 1999; Wilson, 1998]. It is well known that patients with affective components of psychoses have better prognoses than patients with “pure” schizophrenia [Tsuang et al. 2000].

Results of our study demonstrate that gender is not related to development of religious delusions; however, it plays significant role regarding to the content of religious delusions. Impact of gender on the development and course of schizophrenia is well known. For example, it is well documented that in women onset of schizophrenia starts usually much later than in men [Flor-Henry, 1983].

As it was mentioned above religious delusions are more frequent in catholic countries [Stompe et al., 1999]. Lithuania is known as a catholic country and it may have an impact on high prevalence of religious themes in delusions of patients with schizophrenia in this study. Long years of soviet occupation when religion was forbidden may also play a role. Suppressed religious feelings might have to be moved to subconscious level provoking inner conflict, discomfort, confusion, psychosis and related disorders [Rudaleviciene & Narbekovas, 2005; Rudaleviciene & Narbekovas, 2006]. It is suggested that obviously a certain balance of proximity and distance towards religion is necessary for the development of religious delusions [Stompe et al., 2001; Stompe et al., 2006]. Challenge from the official distance towards religion during the soviet period towards absolute religious freedom in nowadays might disturb this balance and provoke development of religious psychopathology, including delusions. Joseph Ratzinger pointed out an importance of religious roots as a foundation of spiritual powers [Ratzinger & Pera, 2006]. During occupation and isolation religious roots of the nation were damaged with no other spiritual source offered [Maceina, 2005]. This longstanding spiritual deprivation might, at least in part, be responsible for the poor mental health situation in Lithuania, including high suicide rate, high alcohol consumption and high prevalence of psychoses [WHO, 2007].

Cross-sectional design of the study does not allow us to speak about causal relationships between independent factors, such as marital status or education and religious delusions. Another limitation of the study is that we did not verify psychiatric diagnoses with standard diagnostic
interviews and relayed on clinical diagnoses; however these clinical diagnoses were established using standard ICD-10 diagnostic criteria for schizophrenia. Moreover, assessing psychopathology we used validated structured psychiatric instrument, FPS.

In conclusion: (1) Delusions of religious content were reported by males and by females. Male patients most often considered themselves as being a God, while female patients most often considered themselves as Saints; (2) Religiosity and personal importance of the faith were not confirmed as independent predictors of religious content of delusions in schizophrenic patients; (3) Marital status and educational level independently predicted religious content of delusions in patients with schizophrenia.

6.2. The impact of personal religiosity on presence and the content of the world end (apocalyptic) delusions in patients with schizophrenia

Respondents reviewed in this paper were of catholic faith that, however, differed in their relation to religious beliefs. One part of respondents comprised those to whom their faith was of personal importance and the rest - for whom it was not. This component was included in discussion and compared in answers on the world end.

Of our total sample 69.8% of schizophrenic patients developed world end delusions once during the course of their illness. Each patient gave an answer in individual way; every answer has been coded in the data base. Every respondent presented his/her individual perception of the world end. We classified these answers according to the themes: religious, modern, global. Several examples are given in this paper. There were cases, when respondents presented both religious and modern views of the world end. Many patients stated that the end of the world has already come.

In the group of patients for whom their faith was of personal importance (n=248) 76.2% felt the upcoming end of the world. But also in the other group (n=47) 36.2% felt the upcoming end of the world too. This was declared expressing both a religious idea of the end of world under the Sacred Scripture, relating to their imaginary higher being and the events met in everyday life, which could be similar to the catastrophe. The belief of the patients that Jesus presupposes the forthcoming end of the world was seen as a catastrophe. “Now brother will betray brother to death, and a father his child; and children will rise up against parents and cause them to be put to death” - Mark 12, 13 [The New Testament, 2006]. Patients said, that it this was “written in Bible”, that “Jesus Christ would come the second time for the ultimate Law”, “Jesus will come and will ask to go on their knees for everyone”, “the war will be, and the tongues of fire as in hell”, “Jesus will come when accompanied by the sounds of buzzing trumpets. Larac found that young individuals had significantly higher scores for items related to suspiciousness and persecutory ideas, paranormal
beliefs and apocalyptic ideas [Larac, 2006]. In our investigation we did not find an age factor influencing apocalyptic ideas, neither influence of gender factor, but the diagnosis.

With clarity and biblical accuracy world end delusions exposes massive errors now flooding through media. These were considered as apocalyptic conceptions of today life, equal to the world end to patients suffering from schizophrenia. Investigation of themes suggested by patients present the picture of the events which bring fearful emotions and vision of the upcoming world end. Unlike most of the apocalyptic preachers of his time, Jesus had little to say of the terrors of the end but because for him this event, usually regarded as far of, was imminent he believed it to be inexorable concern of every living man. In the face of it, everything else paled to insignificance. Whatever remains to do can take on meaning only in the light of this end? Meaning is possible, as for the end: of the world will bring not nothingness but the kingdom of heaven. The kingdom of heaven signifies the era in which God alone will govern. Inevitably it will come, not through any human acts but solely through divine action. 2000 years ago, Jesus predicted what would happen, but he was not merely purveying news to an idle crowd. His message was addressed to the man, who was in the situation which confronted by decision. Each individual is faced with the question of what will become of him in the catastrophe. The end of the world is also a judgment, in which a man is either accepted or rejected by God.

Part of patients’ present world end delusions according the Sacred Scripture and religious themes in Lithuanian psychiatry have been a special and sensitive topic. Long years of soviet occupation have left its cultural inheritance - a conflict between the Lithuanian nation and religion. For a long time religious feelings and beliefs in Lithuania have been suppressed, banned and concealed. Even psychiatrists have often deemed them to psychopathology. Suppressed religious feelings had to be moved to subconscious mind and as a consequence provoked inner conflict, discomfort, confusion and to provoke psychosis within the framework of schizophrenia and related disorders. Contact with God is not yet restored. During psychiatric interview patients are willing to discuss their religious personal religious feelings and beliefs with their psychiatrists.

The affinity of schizophrenia to religion was soon recognized and was a topic for intense research already in the 19th century. Studies demonstrate that religious delusions are frequent in catholic societies. Stompe stated that obviously a certain balance of proximity and distance towards religion is necessary for the development of religious delusions [Stompe, 1999a]. A certain balance of proximity and distance towards religion is necessary for the development of religious delusions. Religion must not be identical with everyday life, but as a system of symbols it must be present in the conscience of a patient.

These were personal ethical norms of life, wanted by individuals to be addressed from others in order to feel comfortable and safe. Lack of ethical and human norms can lead to destruction and
disturbances of the mental state. Bleuler described ethical impulses of particular importance for every being living in society. They preserve the community, and hence they often conflict with interests of the individuals. Moral laws have been in every individual in order for healthy survival. Patients imagine and consider as the end of the world such events of life as “wars”, “terror acts”, “plane crash”, "tsunami" known for them from the media which disturb their psyche and imagination. These culture sensitive events provide systems of symbols which psychotic patients integrate in their efforts of the outer and inner world experienced in their psychoses. Patients read or hear “too many people there are in the world”, “an accident will be in the oil factory this will be the start”. Negative events of personal importance, such as “abortion done by wife”, “infidelity of ones wife” have the power of an “end of personal life” and are equal to the world end. Personal approach to the fearful events was predominant and could be percept as a catastrophe. Bleuler described surroundings can create delusional mood, and give a start for the development of delusions. An interesting finding was the association between the delusions of the end of the world and the marital status of the patients. In our study divorced patients of both genders, developed apocalyptic delusions more frequently than married or single ones perhaps patients living alone experience life more fearful and threatening than those living in close relationships.

Fearful events of these days can sometimes have an impact in the outbreak of psychotic episodes. Clinicians should be aware of the possible impact of terrorist activities on the mental health of vulnerable individuals. Reeves stated that the terrorist attack of September 11, 2001 shocked the world and had devastating effect on many people, including individuals with and without mental illness [Reeves & Beddingfield, 2006]. This terror attack had reflection in Lithuanian psychiatric patient’s delusional content, as well.

In our study we found that those individuals, for whom their faith was no of personal importance, felt the upcoming end of the world less frequently. It seems that the Bible offers symbolic patterns for schizophrenic patients in order to help them to concretize acute psychotic fears.

We the results of our study on apocalyptic delusions pointed out the importance that psychiatrist are sufficiently informed in the big corps of religious knowledge. Already Jaspers stated of religion for the understanding of both everyday life belief as well as of religious delusions. James also said that religion was frequently ignored within the clinical domain, yet when examined, empirical evidence indicated that specific aspects of religiosity were correlated with mental health [James & Wells, 2003]. D’Souza suggested a need to include the spiritual and religious dimension of patients in their psychiatric care. Fabrega noted that the psychiatry of the 21st century would have to be different from the psychiatry of the 20th century and should integrate all facets of knowledge of the behavioral sciences, from biology, pharmacology, sociology, cultural
anthropology, and to serve as providing expert scientific diagnosis and therapy in the light of an appreciation of the role played by cultural factors in shaping human behavior.

**The impact of personal religiosity on presence and content of visual hallucinations in patients with schizophrenia**

Visual hallucinations due to disturbances of perception, and are false perception involving sight consisting of both formed images (for example, people) and unformed images (for example, flashes of light), and are most common in medically determined disorders.

In our study visual hallucinations were found among the other type of hallucinations in the psychopathology of patients suffering from schizophrenia and comprise 39.1% among others, following hallucinations of strange sensations 65.3%, audio (sounds) hallucinations 61.0%, tactile 51.5%, gustatory 48.6%, and audio (voices) 40.5%. Olfactory hallucinations, which follow visual, comprise 28.1%. Respondents of both factors were producing visual hallucinations, where female comprised 43.2%, when male 34.7%. Patients for whom their faith was of personal importance more often see visual hallucinations comparing to those, who do not produce this psychopathology.

Visual hallucinations have played an important role in religion, culture, and all concepts of mental disease. Weller analyzed the pathomechanism involved in the development of visual hallucinationary experiences and argued that no single model could serve to explain all the phenomena encountered in the field of visual hallucinations [Weller & Wiedemann, 1989]. Weller questioned the validity of the current distinction between hallucination and illusion, and delineated conditions which are only appreciable psychologically, e.g. the “imaginary playmates” of childhood and visual hallucinations in the face of a severe grief reaction. He raised the following issues, that at least three putative mechanisms for the genesis of visual hallucinations could be described in biological terminology: irrigative phenomena, release phenomena, and processing disturbances within the visual pathways.

Di Diodoro collected and analyzed visual hallucinations, which had been described in case (medical) histories of the 19th Century as found in the medical archive of the psychiatric hospital “Osservanza” in Imola, located in the Northern Italy, and established that possible resources of this phenomenon could be met in folklore and religious iconographies [Di Diodoro et al., 1998].

Religion is one of the ways how we realize the world and give meaning to our life [Tseng, 2001]. A wide variety of religion exists in different societies and even in one society, and they have effect, either direct or indirect, on our thoughts and behavior. For the said reason, it is of great importance for clinicians, for psychiatrists in particular, to realize the essence of religion and the way how to treat cultural aspects, beliefs and faith. The necessity to renew the interest of
psychiatrists, behavioral and social scientists in religion and its relation to psychiatry and mental health [Neelman & Persaud, 1995; Bhugra, 1996; Koenig et al., 1998; Koenig, 1998; Boehnlein, 2000] is more and more often highlighted. Naturally, representatives of cultural psychiatry should be good experts of aspects of religion in our life and behavior.

From a psychological viewpoint religion is described as a response to contingent and unanticipated situations, other scientists or thinkers characterize religion as the essence of the way of life and see in religion the expression of human perfection. K. G. Jung considered religion to be the means to reach completeness (1912). E. Erikson envisaged hope and wisdom in religion (1963). For S. Freud (1913), religion provided a fulfillment of infantile needs. K. Jasper, whom many consider to be the father of psychiatry and one of the pioneers of cultural psychiatry, and who was a well-known and famous philosopher and psychoanalyst, analyzed the relation of different religions and psychiatry, and stated that a person believing in God was truly free [Jaspers, 1962].

A rather high percentage of the examinees having religious faith (87.4%), observed by us, in our study confirms the importance of faith for our patients. An interesting result was received among men and woman in terms of distribution of gender. Data obtained manifest the following: the percentage of men who specified having religious faith was considerably higher than that of women. Such result received raises certain issues, for example, whether it may be related to the fact that disciples who followed Jesus and proclaimed the Word of God, in the Sacred Scripture, were all men and that only men may seek the occupation of a Catholic priest and be frocked [Sacred Scripture, 1990; Lake, 1996;]. However, such extrapolation from psychopathology to healthy religiosity is groundless. These are theological issues and might be of interest for investigators of theological science.

In the psychiatric practice it is of great importance to differentiate two distinct situations: facing personal religious beliefs of an individual from psychopathology [Rudaleviciene & Narbekovas, 2005]. Religion itself might be either a risk factor or a force for defense in mental patients, and is always of great importance at the onset of delirium symptoms and hallucinations in a patient.

Many psychiatrists state that religion may have a number of positive elements on mental health. Religious beliefs are useful as providing trust, hope, comforting and soothing human thoughts. About 95% of Americans regard themselves as having religious faith, believing in God (in any of the religions) [Tseng, 2001; Boehnlein, 2000], in Switzerland – only 4% of citizens are atheists [Mohr & Huguelt, 2004]. Quite a number of scientific studies were conducted. They have declared that the commitment for religious beliefs is related to health and lower indices of mental illnesses (with self-destructive behavior, abuse of drugs and alcoholic drinks in particular) [Baetz et al., 2002]. Religion is recognized as a potential stress brake [Corin, 1998; Young & Ensing, 1999;
Religious commitments have also effect on lower suicide rates [Kaplan et al., 1994; Tseng, 2001; Mohr & Huguelt, 2004]. Stompe described the former studies demonstrated that in Catholic society, psychopathology of religious content, delirium of religious content in particular, occur more often than among Protestants or Muslims, while among Buddhists are observed extremely rarely. B. Kimura gives such explanation: the foregoing has been determined by structural differences in religions themselves. T. Stompe, with co-authors, having studied the religious component of active psychopathology in Austria and Pakistan, determined that psychopathology of religious content in Austrian patients occurred much more often than in Pakistani patients.

Relation between hallucinations, faith and personal importance of faith has been identified in our study. 42.7 percent of the examinees for whom their faith was personally important saw visual hallucinations; however their number among those whose faith was not personally important for them was twice less. The women for whom their faith was personally important saw visual hallucinations more often than those who did not specify the importance of faith. Relation between the visual hallucinations and importance of faith has not been identified in the male examinees. Earlier, the character of hallucinations was not examined in Lithuania, for the said reason it is impossible to compare what is the dynamics of this psychopathology and what are the differences between, for example, psychopathology in mental patients during the Soviet regime when religion was taboo, and in free Lithuania when liberty in faith and practice exists. Therefore, the present study will serve as the commencement for comparative future studies in Lithuania, and simultaneously – for comparison by investigators in other countries.

In conclusion: (1) Visual hallucinations were observed in more than a third of examinees and no statistically significant difference was established among men and women with schizophrenia in terms of frequency of manifestation of this type hallucinations; (2) The majority of examinees specified having religious faith – men considerably more often than women, and there were considerably more men than women who admitted personal importance of faith; (3) Relations between visual hallucinations, faith and personal importance of faith have been identified. Almost one half of the examinees for whom their faith was personally important saw visual hallucinations; however their number among those whose faith was not personally important for them was twice less; (4) Women for whom their faith was personally important saw visual hallucinations more often than woman who did not indicate personal importance of faith. The relation between visual hallucinations and personal importance of faith has not been identified in male examinees; (5) The onset of schizophrenia at an earlier age (under 20) is an independent factor of manifestation of visual hallucinations.
The impact of culture on psychotic phenomena in schizophrenia

Results from the International multi-center study on the pathoplastic effect of culture are strongly suggestive of an influence of Jewish mystical ideas on the thinking of both Freud and Klein. It was not possible to examine the influence of mystical ideas on other analysts. Every theory however has its critics. Although Bakan suggests that the discipline of psychoanalysis is a secularization of Jewish mysticism, this theory has been disputed by Ostow (1982) who sees little merit in this hypothesis. He argues that whatever mystical element contributed to the creation of psychoanalysis cannot be distinguished from the mysticisms of many other scientists such as Newton and Einstein who sought to elucidate what they consider to be the ultimate unity of the universe.

For Ostow there is nothing to warrant the mysticism in psychoanalysis more closely with Jewish mysticisms than with Christian (the unio mystica) or secular mysticism. The challenge remains to further examine the influence of mystical thought on the development of psychoanalysis. Such a task requires an exploration of religious influence both from within and from outside Judaism which might have influenced Freud’s ideas.

Taking into account the different rates of single contents, hallucinations and FRS in Pakistan and the West-African countries but also four European countries, one has to conclude that the distinction “developed” versus “developing” countries is an over simplification with little explanatory value. Between 15% and 39% of the frequencies of contents of delusions, modalities of hallucinations and first rank symptoms may be caused by differences in the cultures of origin. In contrast between 70 and 85% of the variance of the prevalence of psychotic symptoms does not depend on the culture of origin. This does not mean that more than two thirds of the variance of the symptoms is directly caused by the basic syndromes of schizophrenic disorders [Janzarik, 1988; Klosterkoetter, 1988] or the “lost of the Copernican turn” [Conrad, 2003]. Variables like confession or schizophrenic subtype, age at onset and duration of illness may also contribute to the total variance. The occurrence of different psychotic symptoms could be the result of a combination of the incorporation of culture-specific material and expression of self-organizing pathogenesis of schizophrenia.
6.5. The peculiarities of paranoid-hallucinatory syndromes in schizophrenia in different cultures

Paranoid – hallucinatory syndromes were investigated with the aim to identify these phenomena and to determine their distribution and possible differences in the distribution of these syndromes in different countries. We found seven distinguishable syndromes ("religious grandiosity syndrome", "low perception syndrome", "coenesthetic hypochondria syndrome", "apocalyptic guilt syndrome", "persecutory syndrome", "poisoning syndrome", and "delusional jealousy"). Concerning the second question we found in fact statistically significant differences in six of seven syndromes pointing to a marked impact of culture on the characteristics of psychotic phenomenology:

(1) Patients from Pakistan have an isolated position concerning the “religious grandiosity syndrome”. At least partly this result is in line with the studies on culture and delusions performed by Murphy and his colleagues from the Mc Gill University in the 1969es [Murphy et al., 1963; Murphy, 1967]. Using a completely different study design, also these authors have found low rates of religious delusions in Islamic countries. We were able to further differentiate this result: especially religious themes associated with delusional grandiosity are very rare in Pakistan. In contrast to the European patients no Pakistani claimed that he is God, Jesus, or Mohammed, that means no Pakistani patient experienced a delusional identity [Stompe and Strobl, 2000; Stompe and Ortwein, 2002a; Stompe et al., 2006a]. This result may be due to differences in structure of identity between traditional and modern/post-modern countries: role-and family identity are more important in traditional cultures, personal identity in modern ones. A second important explanation seems to be the strict Islamic prohibition to worship any holy person beside Allah.

2) The high values of apocalyptic guilt could be found in Lithuanian patients. There are two possibilities to interpret this result: (a) in an earlier discussion we pointed out that delusions of guilt are more frequent in Poland and Lithuania than in all other sites [Stompe et al., 2006]. In this chapter the cultural meaning of the association between delusions of guilt and apocalypse ("apocalyptic guilt syndrome") in Lithuania seems to be unclear at the first sight. The syndrome has a religious background (e.g. "The world has come to an end, because I have committed an immortal sin"). Perhaps this difference between the Polish and the Lithuanian patients is due to the different history of the official Christian church in the communistic area a stronger position in Poland, more persecution in Lithuania. Religion in Lithuania was more or less forbidden private issue; (b) the high values of the “apocalyptic guilt syndrome” may be due to different distribution of schizophrenic subtypes in the single sites.
In an earlier paper Stompe have shown that apocalyptic delusions are strongly associated with acute schizophrenia form or schizoaffective disorders [Stompe and Ortwein-Swoboda, 2002b], clinical pictures summarized under term cycloid psychoses by Leonhard [Leonhard, 1999]. However, in that case Lithuanian patients this argument is not very plausible, because the rate of acute forms of schizophrenia was not higher than in the other European countries [Strnad et al., 2006].

This consideration can show that combining single psychotic signs like content of delusions and types of hallucinations to more complex paranoid-hallucinatory syndromes opens up new perspectives for further cross-cultural comparison studies. Several problems and questions for future research resulting: (a) are these syndromes ubiquitous constants of schizophrenic disorders?; (b) to which extent are these paranoid-hallucinatory syndromes culture-sensitive?; (c) are there any other factors like religious confession, social situation, sex, age, age of onset, duration of illness, and schizophrenia subtype influencing the occurrence of these syndromes?

6.6. Evaluation of the attitude of Christian and Muslim patients with schizophrenia towards good and evil

These findings led to the current study on delusions of guilt in schizophrenia through the analysis of a multi-center study on psychotic symptoms. The main interest was not to interpret possible differences in the distribution of certain contents of delusions in Austria, Poland, Lithuania, Pakistan Nigeria and Ghana, but rather to focus on hypothetical trajectories from religious confession to delusions of guilt. To date, only one comprehensive study on this topic exists. In the 1960s, Murphy (1967) conducted a transcultural study examining the experiences of medical professionals from many countries on the frequency of various psychotic phenomena. According to this study, delusions of guilt were often prevalent in Christian countries, while rare in regions under Islamic, Hindu or Buddhist influences. This study intended to address two questions: Are there differences in the one-year prevalence of delusions of guilt in schizophrenia between patients from different cultural backgrounds and confessions? If yes, which religious ideologies have become part of the “anthropological matrix” [Weitbrecht, 1948; 1973] or the social unconsciousness [Erdhaim, 2000] while serving as an attractor for the pathogenesis of religious delusions?

According study performed by Stompe, reported findings, on delusional guilt, which could appear in four different forms: (1) Negative Delusional Identity; patients accuse themselves of having the identity of an evil historical personality (e.g. Hitler) or transcendent character like the Devil [Stompe & Strobl, 2000]; (2) Ontological guilt: patients call themselves as an abstract evil for the whole world; (3) Guilt of action: patients report that they have committed terrible crimes in the
past; (4) Guilt of omission: patients report that they have neglected their duties and brought bad luck to themselves or to their relatives.

Delusions of guilt are a complex phenomenon expressed under the influence of diverse cultural patterns. According to his study, since an association between delusions of guilt and religious tradition seemed to exist independent of culture, it is worth examining the concepts of “Good and Evil” in Christianity and Islam. Theological and philosophical schools have often developed contradictory ideas about such important human ideas as “Good and Evil”, responsibility and guilt, confession and remorse, concepts prevalent in both Christian and Islamic tradition. Concepts of “Good and Evil” are powerful values and collective aspects of individual feelings and delusions of guilt. Therefore, one has to avoid over-hasty trivial assertions when addressing this topic, as cultures and religions have implicit or explicit concepts of “Good and Evil”. The concept of evil contains many different meanings based on the understanding of a certain religion [Schulze, 2003]; malum metaphysicum (traditional finiteness of men), malum physicum (the constitutional evil, natural disaster, illness, natural death), malum cosmicum (a second cosmic power of a deity), malum morale (the guilt, the evil act of the individual bad habits, mischievousness as act of attitude), malum sociale (institutional social evil above the individual), malum theologicum (sin as an act or attitude against a personally understood divinity), malum protologicum (original sin, original evil), or malum eschatologicum (the final disaster, the endless hell, the eternal perdition).

Every culture or ethnicity investigated so far has developed an implicit or explicit moral system, regulating the behavior toward transcendence and other people in semi-legalized way. The difference, however, is found either in the manner in which religions concretize these values, as well as in how they are internalized by the majority of a population, and how cultural patterns produce fears and delusional ideas in mentally ill people.

This discourse about Evil has long and changing tradition in Christianity and Islam. It is unclear which part of their traditions has become an element of the social unconsciousness. The distinctive feature between the three monotheistic religions and the polytheistic religions is the discovery of the moral freedom and the responsibility of men. Beside the “factual” Evil appears ethical Evil. If the ethical Evil is assimilated in a religious context, it is called sin. Both Christianity and Islam can be distinguished from other religions by their focus on the responsibility of men. Stompe reported important differences found in the degree of responsibility between these two monotheistic confessions.

“Good and Evil” and the responsibility of Men in Christianity

In contrast to later speculations about guilt and sin in Early Christianity, the onset of the Kingdom predicted by Jesus Christ is not dependent on the punishment of Evil. This way of thinking is found in passages of the Bible (Roman Letters of St Paul): “Man is justified through...
faith independent from law.” A radical rethinking had already happened at the time of the church fathers (200-400 a. C). In the meantime, Christianity has opened up to the Hellenistic culture, later on growing into a Gnostic world which searched for salvation and deliverance into inner enlightenment, leading out of this world. Christianity reacted to this new situation with spiritual reflection and the development of a consequential ascetic tradition of the desert monks. Body and soul were seen as a seduction and exposed to temptation and offences of demons-the Evil was in around men.

Under the influence of Neo-Platonism, the idea of an absolute ontological predominance of the mind over substance became part of the official Christian dogma. During the fourth and fifth centuries, pessimism with the objective of overcoming the Evil emerged. Augustine (354-430 a. C) who influenced and determined the discourse of Evil in western Christianity foe many centuries, developed under the influence of Manichaeism a dualistic model of the world, divided into a Kingdom of God and a Kingdom of Devil [Augustine, 2004]. He was the first occidental philosopher who tried to unite the border of human freedom with the position of attributable responsibility. His concept of sin resulted in a differentiated introspection and an interest for hidden drives.

Other religious movements also raised the understanding of Evil in the official scholastic theology. In fact this has influenced Stompe and his concept of “good and Evil” until today [Haring, 2003]. At the end of the 13th century, the German and the Dutch mysticism understood Evil in a very concrete way - Evil as an experience of the night, the dark, doubt, and desperation. Even more concrete was the idea of folk piety, which located the power of Evil in human beings, in animals and in objects. While in Judaism and Early Christianity the Devil was not seen as a co-equal counterpart with God, during the 14th century, the Devil as the personification of Evil in competition with God became more important [Minois, 1996]. Although the Devil was seen as the aggregation of collective fears and feelings of guilt during the middle Ages, he is still characterized today as a figure of persecution or negative delusional identity in schizophrenic patients. The third process which is important for this study is the individualization of sin, which began in Europe during the late middle Ages. This idea was also the basis for the compulsion of self-reflex and remorse. A milestone of the Christian persecution of guilt and sin was the canonization of the confession by the Latheran Council (1215 a. C). In the following centuries, the concept of Evil and the responsibilities for men went through various transformations. They provided the basic concept of “God and Evil” and influenced the majority of the members of society. These thoughts can be summarized into four axioms:

1. Ontological meaning of Evil;
2. Evil as part of human nature;
3. Human beings responsible for their evil acts against themselves, against other people, and against God;
4. Human beings and their duty to account even for their thoughts by self-reflection.

“Good and Evil” and the responsibility for men in Islam

As mentioned before, Islam and Christianity confessions share the idea of the responsibility of men. The Qur’an distinguishes between nafs ammara bi ’s-su—(the soul driving to Evil [Qur’an:12;53]) and nafs lawwama is reprimanding soul [Qur’an: 75;2]). The concept of nafs lawwama is reminiscent of the western concept of conscience or the Super Ego [Mujeeb, 1970; Schimmel, 1994]. In Islamic tradition, Evil attracts less attention compared with the European Christian and Jewish traditions. The reason for this minor interest in Evil in comparison to the Christian discourse seems to have primarily theological roots. In Islamic theology, there was no room for an autonomous Evil, because Evil was not directly associated with personhood [Schulze, 2003]. The original sin in Christianity was never mentioned in Islam. Sin in the Islamic dogma stands for an act of the individual. Evil in Islam is not numinous and therefore cannot compete with the numinosity of Allah. A numinous concept of Evil would contradict the basic understanding of the Islamic dogma, because the existence of a unique transcendent God does not accept a co-equal counterpart. We can still find the character of the Devil in classical Arabian poetry and prose, but the Devil does not really possess the character of a seducer or an adversary of God. From an ontological perspective, the Devil does not exist as an individual, in Islam personifying absolute Evil as in Christianity. Evil is mostly thought of as a demon. In early Islamic tradition we meet the character of the Devil in two different figures: one is “Shaitan” the other “Iblis” [Awn, 1983]. Although their shapes and actions are both characterized as evil, the Devil is not personalized as the embodiment of evil, and hence, the incarnation of all Evil. The personification of Evil in Christianity cannot be found in the Qur’an. Evil appears in one of four characters:

1. Bad omen;
2. The moral quality of a deed;
3. The attribute of acts of the Devil (Shaitan, Iblis);
4. Examination by God.

Controversial speculations about the freedom of man’s choice also have their roots in the Qur’an:

If something good is happening, they say this is from God, and if something bad is happening, they say this is from yourself, you have to say, that all comes from Go. (Qur’an:4:78).

If something good is happening, it is from God, and if something bad is happening, it comes from you (Sura: 4:79).
The first sentence was repeatedly the basis for a radical discourse about predestination. In the 8th century, such theological schools as the “Mu'tazilites” tried to focus on the second sentence and, therefore, further emphasize the responsibility for men [Mainz, 1935]. On the other hand, the “Asharities,” a rival theological school, claimed that Evil comes from disobeying God’s commands which came by revelation.

The predestination with its popular character of “Kismet” had a great impact on the social unconsciousness of Islamic society. Since understanding the concepts of sin and salvation in Islam is the focal point at this juncture in the study, further reports on theological and philosophical Islamic schools which made important contributions to this theme do not add pertinent data to this study. Important for its understanding, however, is not primarily the culpable behavior in daily life, but rather the breach of religious rules. The commitment to Islam implicates salvation, in particular, since Islam stresses the mercy of God covering the faults of the sinner. The threat of condemnation does not address the Islamic sinner per se, but rather, the heathen.

The following are the most popular attitudes in the discourse of “Good and Evil” and the responsibility for men in Islam:

1. No ontological Evil;
2. No personification of Evil;
3. Religious sins are more significant compared to profane interactional sins;
4. Good and Evil come from God;
5. Predestination.

Consequences for the psychopathology of guilt

Dogmatic positions towards “Good and Evil” were transformed by folk religion over centuries, and became part of the social unconsciousness [Erdheim, 2000] influencing value systems, including those of Agnostics. These cultural patterns are internalized by familiar and other socializing agents, and have become part of regular such internal instances as the super ego or the ego ideal. Members of such religions as Hindus (Karma) and Muslims (Kismet) who believe more in predestination than in personal responsibility will experience delusions of guilt less frequently than Christians. There are no collective or individual grounds for delusional ontological guilt in cultures predominant by religions without a concept of ontological sin. Only members of religions with a pronounced personification of Evil may develop negative delusional identities.

Limitations consist of the impossible to describe and list all traditions that may contribute to the study of this topic. As the study is cross-sectional the influence of religious confession on the pathogenesis of delusions of guilt can only be postulated indirectly. Further studies are necessary to prove the association between individual religiosity and delusional guilt, and to scrutinize culture-specific actions and reflections on delusions of guilt (e.g. suicidal behavior).
7. CONCLUSIONS

1. Personal importance of faith was not confirmed as an independent predictor of religious delusions in patients with schizophrenia, but marital status and educational level. Female patients most often considered themselves as Saints, whereas male patients most often considered themselves as being a God.

2. Schizophrenia patients for whom their faith is of personal importance feel the coming end of world more often than those for whom it is not. Higher prevalence of the world end delusions was found among divorced patients as compared to those who lived in the family. Female patients reported the world end delusions with religious content (apocalyptic) more often than the male patients. Male patients as compared to female patients more often reported world end delusion with global content.

3. Patients with schizophrenia for whom their faith was of personal importance compared to patients with schizophrenia for whom their faith was not of personal importance had higher prevalence of visual hallucinations. The early onset of illness (age until 20) and personal importance of faith were independent predictors of development of visual hallucinations.

4. In seven different countries with different cultural, ethnical and religious background majority of psychotic symptoms in patients with schizophrenia were culture unspecific. Schneider’s first rank symptoms were most culture specific as compared to content of delusions and hallucinations.

5. Content of paranoid hallucinatory syndrome of patients with schizophrenia was different in different countries. Differences in religious grandiosity, low perceptions, coenesthetic hypochondria, apocalyptic guilt, persecutory syndrome and poisoning syndrome, but not jealousy reached statistical significance. Lithuanian patients showed higher mean values of ‘apocalyptic guilt syndrome’ than patients from all other countries.

6. Catholic patients with schizophrenia compared to Muslims patients with schizophrenia had higher prevalence of delusions of guilt. The highest prevalence of delusions of guilt was found in the Lithuanian group of patients reaching one quarter, and the lowest prevalence of delusions of guilt was found in Pakistani group of patients reaching one percent.
8. SCIENTIFIC MEANING OF THE STUDY

New information of scientific value is contained in this study. The impact of personal religiosity and culture on the psychotic symptoms in patients with schizophrenia is examined and presented. Content of delusions in patients with schizophrenia is evaluated and described. This would be an input for the databases for future cross-cultural studies in psychiatry.
9. PRACTICAL RECOMMENDATIONS

I. Clinical Implications
1. Parallel to evaluation of psychopathology, cultural assessment of mentally ill patient, including his/her personal problems, religious beliefs and values system is recommended to perform when diagnosing, differentiating mental disorders and modelling treatment plan design.
2. Psychiatrist should be aware of religious anamnesis of his/her mentally ill patient. Religious beliefs of the patients should be respected.
3. It is recommended to provide treatment for mentally ill patient according his/her beliefs, values, cultural background and a need for spirituality parallel to pharmacotherapy and psychotherapy.
4. The Instrument is recommended for psychiatrist in order to perform the evaluation of the content of psychotic symptoms.

II. Education
1. It is recommended to incorporate a course of Cultural Psychiatry into the teaching programmes for medical students.
2. It is recommended to incorporate a course of Cultural Psychiatry into the CPD programmes for psychiatrists.
3. It is recommended to incorporate a teaching course of Theology into the teaching programmes for psychiatrists.

III. Continuous research
To continue the research analysing the data collected.

IV. Scientific collaboration
To establish and perform collaboration with research centres on Cultural Psychiatry in the countries of the European Union as well as with research centres in other countries of the world.
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Thesis:


12. ANNEXES
PERMIT FROM BIOETHICS COMMITTEE

LEIDIMAS ATLIKTI BIOMEDICININĮ TYRIMĄ

2006-06-22 Nr.: 30

Biomedicininio tyrimo pavadinimas:
Kultūrinės psichiatrijos tyrimas. Vilniaus miesto psichikos sveikatos centre besigydančių pacientų klídesių ir halucinacijų turinys

Protokolo Nr.: 926
Data: 2006 m. gegužės 23 d.

Asmens informavimo ir informuoto asmens sutikimo forma:
Versijos Nr.: 26
Data: 2006 m. birželio 21 d.

Pagrindiniai tyrejai: Gyd. Palmira Rudalevičienė

Biomedicininio tyrimo vieta:
Ištaigos pavadinimas: Vilniaus miesto psichikos sveikatos centras
Ištaigos adresas: Vasaros g. 5, Vilnius

Leidimas išduotas Lietuvos bioetikos komiteto posėdžio, vykusio 2006 m. birželio 20 d., sprendimu.

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<tr>
<td>1</td>
<td>Gyd. Gintare Booviene</td>
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<td>2</td>
<td>Gyd. Vytautas Čepulis</td>
<td>onkologa</td>
<td>taip</td>
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<td>3</td>
<td>Doc. Eugenijus Grėfenas</td>
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<td>4</td>
<td>Doc. Zina Lieburksiene</td>
<td>filosofija</td>
<td>ne</td>
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<td>5</td>
<td>Dr. Andrius Narbekovas</td>
<td>teologa</td>
<td>ne</td>
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<td>6</td>
<td>Prof. Algimantas Raugolė</td>
<td>pediatra</td>
<td>taip</td>
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<td>7</td>
<td>Doc. Krešcentas Štolas</td>
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<td>8</td>
<td>Gyd. Vytautas Tutkus</td>
<td>mikrochirurgija</td>
<td>taip</td>
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<tr>
<td>9</td>
<td>Dalia Zeleikienė</td>
<td>teise</td>
<td>taip</td>
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Lietuvos bioetikos komitetas dirba vadovaudamas Geros Klinikinės Praktikos taisyklėmis, kurius siūloma pristatyti Europos Sąjungos, Japonijos ir JAV valdžios struktūroms

1. e. pirmininko pareigas

Vilma Lukaševičienė
Title:
Research in Cultural Psychiatry, Content of Delusions and Hallucinations

Protocol No.: 926
Dated: 23 May, 2006

Patient information sheet and informed consent form:
Version: 26
Dated: 21 June, 2006

Principal Investigator: Palmira Rudalevičienė, M.D.

Biomedical research site:
Name of institution: Vilnius Mental Health Care Centre
Address of institution: Vasaros str. 5, Vilnius

Approval is issued according to the decision of the Lithuanian Bioethics Committee meeting of 20 June, 2006

<table>
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<th>No.</th>
<th>Name</th>
<th>Occupation</th>
<th>Presence in the meeting</th>
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<tr>
<td>1</td>
<td>Gintare Breuviienė, M.D.</td>
<td>pediatrician</td>
<td>Yes</td>
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<tr>
<td>2</td>
<td>Vytautas Cepulis, M.D.</td>
<td>oncologist</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Eugenijus Gegenas, Assoc.Prof.</td>
<td>bioethicist</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Zita Liubarskiene, Assoc.Prof.</td>
<td>philosopher</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>Andrius Narbekovas, Ph.D.</td>
<td>priest</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>Algimantas Raugale, Prof.</td>
<td>pediatrician</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Krescentius Stroiuks, Assoc.Prof.</td>
<td>philosopher</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Vytautas Tuikus, M.D.</td>
<td>micro surgeon</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>Dalia Zeleckiene</td>
<td>lawyer</td>
<td>Yes</td>
</tr>
</tbody>
</table>

LBEC works in compliance with the International Harmonized Good Clinical Practice Guideline, recommended for adoption to the regulatory bodies of the European Union, Japan and USA

Acting Chairman
Vilma Lukaševičienė
Annexe 2

COMPLETION INSTRUCTIONS

ASMENS INFORMAVIMO BEI INFORMUOTO ASMENS SUTIKIMO FORMA

Gerb. _________________________________

Kviečiame Jus dalyvauti mūsų gydymo įstaigos atliekamame moksliniame tyrime „Kultūrinės psychiatrijos tyrimas. Vilniaus miesto psichikos sveikatos centre besigydančių pacientų kliedesių ir halucinacijų turinys“.

Prašome susipažinti su informacija apie tyrimą.

Šio mokslo tyrimo tikslas – rasti ir įvertinti Vilniaus miesto psychikos sveikatos centre besigydančių pacientų, sergančių šizofrenija, šizoafektiniu bei šizotipiniu sutrikimu, produkuojamų aktyvios psychopatologijos simptomų – kliedesių ir halucinacijų – turinio ypatumus.

Su jumis gydytoja (tyrėja) kalbės ir užduos klausimus, kurie užduodami kiekvienam pacientui, siekiant įvertinti jo mąstymo ir suvokimo sferas – nepriklausomai, ar jūs dalyvaujate tyrime ar ne. Todėl jūs nepatisite jokių papildomų nepatogumų, iš jūsų nereikės jokių papildomų žinių ar pastangų – tik atsakyti į užduodamus klausimus. Tai bus išprastas pokalbis su gydytoja, taip yra kalbinamas kiekvienas pacientas, atvykęs pas psichiatrą ieškoti pagalbos.

Jūsų sutikimas dalyvauti tyrime gydytojai leistų jūsų atsakymus analizuoti, apibendrinti, daryti išvadas.

Šiame tyrimo bus panaudota palyginamoji Vienos (Austrijos) psychiatrijos profesoriaus T. Stompe sukurtą anketa, kuri buvo taikyta ir kitų pacientų apklausai, tačiau nebuvo naudota Lietuvoje. Tyrėja (gyd. P. Rudalevičienė) anketą išvertė į lietuvių kalbą ir naudoja savo kasdieniniame darbe nustatant ligos diagnozę.

Dalyvauti tyrime yra kviečiami asmenys, kurie nurodytu laikotarpiu (2006.07.01 – 2006.12.01) kreipsis psichiatro konsultacijai į Vilniaus miesto psychikos sveikatos centro Konsultacinį centrą, arba tuo laikotarpiu bus gydomi psychiatriškai stacionare Vilniaus miesto psychikos sveikatos centre, ir kuriems bus diagnozuojama (arba – jeigu gydymo kursas kartojuamas – jau diagnoizuota) šizofrenija, šizoafektinis arba šizotipinis sutrikimas.

Jūs tyrime dalyvaujate, išsakydamas (-a) savo nusikundimus savo iniciatyva ir atsakydamas (-a) į gydytojo psichiatro užduodamus klausimus.

Kuo Jums gali būti naudingas planuojamas tyrimas?
Šis tyrimas gali būti naudingas jums, kadangi galėsite daugiau sužinoti apie savo susirgimą ir savo paties psichinę būklę, ją aptarti. Tai padidins jūsų pasitikėjimą savimi, pasitikėjimą savo gydytojo, sudarys jums galimybę tapti gydytojo partneriu jūsų ligos gydyme.

Kaip dažnai reikės atvykti į tyrimo vietą?

Dalyvavimo savanoriškumas
Dalyvavimas šiame tyроме yra visiškai savanoriškas. Jei atsisakysite dalyvauti, Jūs būsite stebima(-s) ir toliau gydoma(-s) kaip įprasta, būsite ir toliau gydoma(-s) ir gausite visą reikiamą pagalbą.
Jūs taip pat galite bet kada pasitraukti iš tyrimo, jei prieš tai buvote sutikęs dalyvauti. Tai niekaip neįtakos tolesnės Jūsų sveikatos priežiūros.

**Išlaidos dėl dalyvavimo biomediciniame tyrime bei numatoma kompensacija už dalyvavimą tyrome**

Dėl dalyvavimo tyrome Jūs neturėsite papildomų išlaidų. Taip pat už dalyvavimą tyrome nenumatoma jokia kompensacija.

**Konfidencialumo apsauga**


Visais su tyrimu susijusiais iškilusiais neaiškumais prašome kreiptis šiais telefonais:

Tyrėja gyd. P. Rudalevičienė – 262 59 79
Vilniaus miesto psichikos sveikatos centro direktorius M. Marcinkevičius – 262 55 69

Dėl savo, kaip tyrimo dalyvio, teisių, galite kreiptis į Lietuvos bioetikos komitetą tel. (8~5) 212 45 65.

**INFORMUOTO ASMENS SUTIKIMO FORMA**

Aš perskaičiau šią informaciją ir man buvo paaiškintas jos turinys. Aš sutinku dalyvauti šiame moksliniame tyrime. Į visus savo klausimus gavau mane patenkinusius atsakymus.

Pacentas: ________________________________________________________________

(vardas, pavardė, data)

Tyrėjas: ________________________________________________________________

(vardas, pavardė, data)

1. Liudytojas (nepriklausomas asmuo) __________________________________________

(vardas, pavardė, data)

2. Liudytojas (nepriklausomas asmuo) __________________________________________

(vardas, pavardė, data)

Sveikatos priežiūros įstaigos vadovas _______________________________________

(vardas, pavardė, data)
QUESTIONNAIRE

RESEARCH IN CULTURAL PSYCHIATRY (Schizophrenia Sto.Ru)

STRUCTURED CLINICAL INTERVIEW (SCI)

Country:  
Town:  
Patient  
Control person  
Name:  
Sex:  
Birth Data:  
Marital status:  
Originates from:  
Rural  
Urban  

Religion: 1. Are you religious person?

Yes  
No  

2. According my religious beliefs I am:

Catholic  
Muslim  
Buddhist  
Hindu  
Other  

3. Is your faith personally important for you?  
Yes  
No  

4. Do you have the possibility to realize your religious feelings?  
Yes  
No  

Household size during childhood:  
Household size the last six months before the recent admission:  

Highest educational level achieved:  
Occupation:  
Number of weeks employed during the last 6 months  
Before the recent admission:  

Occupation of the father:  
Occupation of the mother:  

Age of father:  
Age of mother:  

Sibship size:  
Order of Birth:
2. Patient only

Subtype of schizophrenia according to ICD-10
Age at onset of disease:
Best estimate of number of episodes or periods:
Course:

Number of psychotic first grade relatives:
Who?

Questionnaire on Delusions and Hallucinations

Introduction

This questionnaire serves the purpose of investigating delusional and hallucinatory phenomena. These experiences of schizophrenic patients over the last six months shall be inquired into. If the Patient’s answers are inadequate, the following exploratory devices may be used:

If the patient’s answer is too short:

Could you tell me more about it?

If the patient gets stuck:

What further difficulties did you have?

If the answer is obscure:

Could you explain me what you mean by…?

If the answer is vague:

Could you give me an example for that?

If the patient gives no further answer:

Why were you hospitalized?

3. Delusional themes

If any of following questions is answered with yes, make sure that it is a delusional experience but not personal or cultural belief! A delusion is characterized by the following criteria:

1. Subjective certainty
2. Not modified by convincing conclusions or experiences
3. Plausibility of the delusional content has no differential value
4. Shared cultural believes are not delusional
1. Did anyone try to inflict harm on you? Or did you feel persecuted or threatened?
   - Yes □ No □ → if not go to 2nd
   - In which way do you feel persecuted? →
   - By whom do you fell…? →
   - For what reason are you persecuted or threatened? →

2. Did you gain the impression that someone would try to poison you?
   - Yes □ No □ → if not go to 3rd
   - If yes, who and why? →

3. Do you think that you are incurably sick, that your organs are somehow altered or that you decay and will die soon?
   - Yes □ No □ → if not go to 4th

4a. Did you sense a vacation for something extraordinary?
   - Yes □ No □ → if not go to 4th
   - If yes, for what? →

4b. Did you think you were an important personality, a saint, God, the devil or a demon?
   - Yes □ No □ → if not go to 4th
   - If yes, who? →

4c. Did you feel as if you were equipped with special faculties?
   - Yes □ No □ → if not go to 4th
   - If yes, what faculties? →

4d. Did you think you owned opulent riches which no one else suspecting it?
   - Yes □ No □ → if not go to 4th

5a. Did you think that your family was actually not your real family but that you were related to someone else?
   - Yes □ No □ → if not go to 6th

5b. Do you believe you are of superior descent?
   - Yes □ No □ → if not go to 6th

6a. Do you think you have committed a crime or a mortal sin by offending someone?
   - Yes □ No □ → if not go to 6th
   - If yes, what was it? →
   - Against whom? →

6b. Do you think you have committed a crime or a mortal sin by not doing your duty?
   - Yes □ No □ → if not go to 6th
   - If yes, what was it? →
   - Against whom? →
6c. Is your sheer existence a sin or a crime?
Yes ☐ No ☐
-Against whom? →

6d. Did you feel guilty by being luckier than the others?
Yes ☐ No ☐
-in which way? →
-Do you feel you deserve punishment?
Yes ☐ No ☐
-If yes, what punishment? →

7. Did you feel loved by someone although the person concerned never told you so or even denied it or although your relatives and friends did not share your view?
Yes ☐ No ☐ → if not go to 8th
-If yes who was it? →

8. Did you feel the world had come to an end or would soon come to an end?
Yes ☐ No ☐ →
-If yes, why and which way? →

9. Did you feel pregnant although all the others thought you were not?
Yes ☐ No ☐ → if not go to 10th

10. Did you think your partner had betrayed you although he (or she) always vehemently denied it?
Yes ☐ No ☐ → if not go to 11th

11. Did you feel that actually you died but that the others had simply not realized that?
Yes ☐ No ☐ → if not go to 12th

12. Did you believe you had risen from the dead?
Yes ☐ No ☐ → if not go to 13th

13. Did you feel afflicted with vermin although your relatives and the doctors tried to convince you were not?
Yes ☐ No ☐ → if not go to 14th

14. Did you sense you had become poor did not own anything any more?
Yes ☐ No ☐

**Delusional system**

Assessment:

-Contents of delusion are not converted into a certain system which influences most of the patients experiences. Contents of delusion and hallucinations can exist isolated from one another.
- Patients judges nearly all his experiences by the perspective of his contents of delusion.
Logical Arrangement of Delusion

Assessment:
- Basic assumptions and conclusions are within the range of eventuality, e.g. “the neighbors want to poison me because they need my apartment.”

- The basic assumption is illogical, the conclusion is logical e.g. “the world has come to end because a nuclear war has taken place.”

- The basic assumption is logical, the conclusion is illogical e.g. “the environment is polluted because at night angles used to fly around the sun.”

- Basic assumptions and conclusions are illogical e.g. “I am Jesus Christ because the birds keep flying after me.”

Duration of illness

1. With phasic course, onset of the present phase
   - Since when do you felt worse?
   - Since when have your relatives noticed changes with you?
2. With all types of course, age at first onset present ones?
   - When did you first have problems similar to your present ones?

Schneider’s First Rank Symptoms

- Have you recently had any kind of perception that had a clear undoubtable meaning to you while others judged this meaning abnormal and could find no rational or emotional reason to see things like you did?

  Yes ☐ No ☐

- Did you have the impression, over the last weeks, that people you know are actually strangers or that they are in fact prominent personalities?

  Yes ☐ No ☐ give us an example →

- Did it happen, during the last weeks, to take strangers for acquaintances e.g. that you thought that the doctor were your brother or something like that?

  Yes ☐ No ☐ give us an example →
- Did you feel, over the last weeks, as if your thoughts left your head and spread? could others hear your thoughts?

  Yes ☐  No ☐

- Did you feel as if other persons inserted thoughts in you?

  Yes ☐  No ☐

- Did as if other person have withdrawn thoughts from you?

  Yes ☐  No ☐

- Did your thoughts within your head become audible for yourselves?

  Yes ☐  No ☐

- Did you hear voices commenting on what you are just doing although there was no one in the room or although no person have talked to you?

  Yes ☐  No ☐

- Did you hear voices talking to one another although no one was there?

  Yes ☐  No ☐

- Did you have the impression as if your will was directed by a power or force from outside?

  Yes ☐  No ☐

- Did you have the impression as if your emotions were directed by a power or force from outside?

  Yes ☐  No ☐

- Did you have an impression as if your thoughts were directed by a power or force from outside?

  Yes ☐  No ☐

- Did you have an impression as if you movements were directed by a power or force from outside?

  Yes ☐  No ☐

- Did you have an impression as if your body was changed or damaged by a power or a force from outside?

  Yes ☐  No ☐
**Hallucinations**

- Do you hear sounds like e.g. knocking or music?
  
  Yes ☐  No ☐
  
  If yes, which?  

- Do you hear other kind of voices?
  
  Yes ☐  No ☐
  
  - Who spoke to you?  
  
  - What did he/she tell you?  

- Do you sometimes converse with these voices?
  
  Yes ☐  No ☐
  
- Have you ever experienced a vision or seen things which people have not?
  
  Yes ☐  No ☐
  
  - if yes, which?  
  
  - were there scenes or static pictures?  

- Do you sometimes notice strange smells which are not noticed by other people?
  
  Yes ☐  No ☐
  
- Have you ever felt that someone or something touched you although no one was present?
  
  Yes ☐  No ☐
  
- Have you observed recently that your meals have an odd taste?
  
  Yes ☐  No ☐
  
- Have you perceived strange sensations from the inner of your body like for example electric current, burning sensations, swelling or shrinking of organs or others?
  
  Yes ☐  No ☐
  
  - what kind of sensations?  


TARPKULTŪRINIS TYRIMAS (Šizofrenija, sto, ru)

Šalis: Miestas

Pacentas ☐ Kontrolinis asmuo ☐

Kodas: Lytis:

Gimimo data: Šeimyninė padėtis:

Kilęs iš:

Kaimo ☐ Miesto: ☐

Religija: 1. Tikintis (-i)

  - taip ☐
  - ne ☐

2. Pagal savo religinius įsitikinimus esu:

  - katalikas ☐
  - musulmonas ☐
  - budistas ☐
  - induistas ☐
  - kt. ☐

3. Ar jums asmeniškai jūsų tikėjimas yra svarbus? Taip ☐ Ne ☐

4. Ar turite galimybę savo religinius jausmus realizuoti? Taip ☐ Ne ☐

Šeimos dydis vaikystėje:

Šeimos dydis pusmetį prieš paskutinę hospitalizaciją:

Aukščiausias pasiektais išsilavinimas:

Darbas:

Kiek savaičių dirbta per pusmetį iki paskutinės hospitalizacijos:

Tėvo darbovieta:

Motinos darbovieta:

Tėvo amžius: Motinos amžius:

Broliai ir seserys (paciento ar kontrolinio asmens):

Gimimo eiliškumas (paciento ar kontrolinio asmens atžvilgiu):

---

Tik pacientams

Šizofrenijos porūšis pagal DSM-IV: Paūmėjimų skaičius:

Amžius ligos pradžioje: Eiga

Psichikos ligomis pirmos eilės giminaicių skaičius: Rūšys
Klausimai kliedesių tema

Jei į nors vieną žemiau esančių klausimų gaunamas atsakymas „taip“, įsitikinkite, kad tai tikrai yra kliedesys, o ne asmeninis ar kultūrinis įsitikinimas! Kliedesys diferencijuojamas, remiantis šiais kriterijais:

1. Subjektyvus tikrumas
2. Nuomonės nepakeičia įtikinamos išvados ar patirtis
3. Kliedesio turinio patikimumas neturi diferencinės vertės
4. Bendri tam tikrai kultūrai būdingi įsitikinimai nėra kliedesiai

1. Ar kas nors mėgino Jus nuskriausti? Ar Jūs jaučiatės persekiojami, ar Jums kas nors grasina?

Taip ☐ Ne ☐

Jei ne, pereikite prie antro klausimo

- Kaip Jūs jaučiate persekiojimą?
- Kas Jus persekioja?
- Dėl kokios priežasties Jus persekioja ar Jums grasina?

2. Ar Jums susidarė įspūdis, jog kas nors mėgina Jus nunuodyti?

Taip ☐ Ne ☐

Jei ne, pereikite prie trečio klausimo

- Jei taip, tai kas, kaip ir kodėl?

3. Ar manote, jog sergate nepagydoma liga, kad Jūsų organai yra kažkaip pakitę, arba kad Jūsų sveikata silpnėja ir Jūs greitai mirsite?

Taip ☐ Ne ☐

Jei ne, pereikite prie ketvirto klausimo

4a. Ar Jūs pajutote polinkį (pašaukimą) kokiam nors neįprastam dalykui?

Taip 0 Ne 0

4b. Ar manėte esanti svarbi asmenybė – šventasis, Dievas, velnias ar demonas?

Taip ☐ Ne ☐

Jei taip, kas konkrečiai?

4c. Ar jautėte, kad Jūs turite ypatingų sugebėjimų?

Taip ☐ Ne ☐

Jei taip, kokių konkrečiai sugebėjimų?

4d. Ar manėte turėtų turėtų ypatingų turtų, kurių neįtaria niekas kitas?

Taip ☐ Ne ☐
5a. Ar manėte, kad Jūsų šeima nėra Jūsų tikroji šeima, ir kad Jūs susiję su kažkuo kitu?
Taip ☐ Ne ☐

5b. Ar manote esantis aukštesnės kilmės?
Taip 0 Ne 0 Jei nei, pereikite prie šešto klausimo

6a. Ar manote, kad padarėte nusikaltimą ar mirtiną nuodėmę ką nors įžeidęs?
Taip ☐ Ne ☐
- Jei taip, kas tai buvo?
- Prieš ką Jūs nusikaltote?

6b. Ar manote, kad padarėte nusikaltimą ar mirtiną nuodėmę neatlikęs savo pareigos?
Taip ☐ Ne ☐
- Jei taip, kas tai buvo?
- Prieš ką Jūs nusikaltote?

6c. Ar vien tai, kad Jūs egzistuojate, yra nuodėmė ar nusikaltimas?
Taip ☐ Ne ☐
- Prieš ką Jūs nusikaltote?

6d. Ar jautėtės kalti būdami laimingesni už kitus?
Taip ☐ Ne ☐
- Kokiu būdu?
- Ar jaučiatės verti baumsės?
Taip ☐ Ne ☐
- Jei taip, kokios baumsės konkrečiai?

7. Ar jautėte, kad Jus kažkas myli, nors tas asmuo niekuomet Jums taip nesakė ir netgi neigė tai, ir Jūsų giminačiai bei draugai nesutiko su Jumis?
Taip ☐ Ne ☐ Jei ne, pereikite prie aštunto klausimo
- Jei taip, kas tai buvo konkrečiai?

8. Ar jautėte, kad atėjo arba netrukus ateis pasaulio pabaiga?
Taip □ Ne □  Jei ne, pereikite prie devinto klausimo

- Jei taip, kodėl ir kokių būdu?

9. **Ar jautėtės esanti nėščia, nors visi kiti manė, kad taip nėra?**

Taip □ Ne □  Jei ne, pereikite prie dešimto klausimo

10. **Ar manėte, kad Jūsų partneris išdavė Jus, nors jis(ji) visuomet tai tvirtai neigė?**

Taip □ Ne □  Jei ne, pereikite prie vienuolikto klausimo

11. **Ar jautėte, kad faktiškai Jūs mirėte, bet kiti paprasčiausiai to nesuprato?**

Taip □ Ne □  Jei ne, pereikite prie dvylirkto klausimo

12. **Ar manėte, kad prisikėlėte iš numirusių?**

Taip □ Ne □  Jei ne, pereikite prie trylikto klausimo

13. **Ar jautėte, kad Jus apniko parazitai, nors Jūsų giminės ir gydytojai mėgino Jus įtikinti, kad taip nėra?**

Taip □ Ne □  Jei ne, pereikite prie keturiolikto klausimo

14. **Ar patyrėte jausmą, kad tapote neturtingu ir nieko neturinčiu?**

Taip □ Ne □

**Kliedesų sistema**

Vertinimas

- Kliedesų turinys nepereina į jokią sistemą, kuri gali įtakoti pacientų išgyvenimus. Kliedesų ir haliucinacijų turinys gali egzistuoti vienas nuo kitų atskarai.

- Pacientas sprendžia apie visus savo išgyvenimus pagal savo kliedesų turinį.

**Loginis kliedesų interpretavimas**

Vertinimas:

- Pagrindinės prielaidos ir išvados paremtos atsitiktinumais, pvz.: „kaimynai nori mane nunuodyti, nes jiems reikia mano buto“.

- Pagrindinė prielaida yra nelogiška, bet išvada logiška, pvz.: „pasaulio pabaiga atėjo todėl, kad įvyko branduolinis karas“.

- Pagrindinė prielaida yra logiška, bet išvada nelogiška, pvz.: „aplinka yra užteršta todėl, kad naktį velniai skraido aplink saulę“.
- Pagrindinės priežaidos ir išvados yra nelogiškos, pvz.: „Aš esu Jėzus Kristus, nes paukščiai skrenda paskui mane“.

Ligos trukmė

1. Ligos etapai; dabartinio etapo trukmė

   - Kada Jūs pasijutote blogiau?
   - Kada Jūsų giminės pastebėjo, kad Jūs pasikeitėte?

2. Amžius ligos pradžioje

   - Kada Jūs pirmą kartą susidūrėte su panašiomis problemomis?

   **Schneider‘io pirmo rango simptomai**

   - Ar pastaruoju metu esate suvokė ką nors, kas turėjo Jums aiškią neabejotiną reikšmę, tuo tarpu kai kiti tą reikšmę laikė neįprastai ir negalėjo rasti jokių racionalių ar emocinių priežasčių matyti dalykus taip kaip Jūs matote?
   
   Taip  □  Ne □

   - Ar pastarosiomis savaitėmis Jums buvo susidaręs įspūdis, kad Jūsų pažįstami žmonės iš tikrųjų yra svetimi arba kad jie yra garsios asmenybės?
   
   Taip  □  Ne □

   - Ar pastarosiomis savaitėmis Jums yra tekę palaikyti svetimus žmones savo pažįstamais, pvz. Jūs manėte, kad gydytojas yra Jūsų brolis ar panašiai?
   
   Taip  □  Ne □

   - Ar pastarosiomis savaitėmis Jūs jautėtės taip tarytum Jūsų mintys paliko Jus ir išsisklaidė? Ar kiti galėjo girdėti Jūsų mintis?
   
   Taip  □  Ne □

   - Ar jautėtės taip, tarytum kiti žmonės įdėjo mintis į Jūsų galvą?
   
   Taip  □  Ne □

   - Ar jautėtės taip, tarytum kiti žmonės atėmė Jūsų mintis?
   
   Taip  □  Ne □

   - Ar Jūs pradėjote girdėti mintis savo galvoje?
   
   Taip  □  Ne □
- Ar girdėjote balsus, komentuojančius tai ką darote, nors nieko nebuvo kambaryje ir niekas su Jumis nekalbėjo?
   Taip  Ne

- Ar girdėjote balsus, kalbančius tarpusavy, nors nieko nebuvo šalia?
   Taip  Ne

- Ar Jums susidarė įspūdis, kad Jūsų valią valdo išorinė jėga?
   Taip  Ne

- Ar Jums susidarė įspūdis, kad Jūsų emocijas valdo išorinė jėga?
   Taip  Ne

- Ar Jums susidarė įspūdis, kad Jūsų mintis valdo išorinė jėga?
   Taip  Ne

- Ar Jums susidarė įspūdis, kad Jūsų jūdesius valdo išorinė jėga?
   Taip  Ne

- Ar Jums susidarė įspūdis, kad išorinė jėga pakeitė ar sužalojo Jūsų kūną?
   Taip  Ne

   **Hallucinacijos**

- Ar girdite garsus, panašius, pavyzdžiui, į beldimą į duris ar muziką?
   Taip  Ne

   Jei taip, kokius konkrečiai?

   - Ar girdite kitus balsus?
   Taip  Ne

   - Kas kalbėjosi su Jumis?
   - Ką jis/ji pasakė Jums?
   - Ar Jūs kartais kalbate su tais balsais?
   Taip  Ne

   - Ar esate kada nors matę viziją ar daiktus, kurių kiti žmonės nematė?
   Taip  Ne
Ješi taip, ką konkrečiai?

- Ar tai buvo scenos, ar statiški vaizdiniai?
- *Ar kartais jaučiate keistus kvapus, kurių nejaučia kiti žmonės?*

Taip □ Ne □

- *Ar kada nors jautėte, jog kažkas Jus liečia, nors nieko nebuvo šalia?*

Taip □ Ne □

- *Ar pastaruoju metu nepastebėjote, kad Jūsų maistas turi keistą skonį?*

Taip □ Ne □

- *Ar nejautėte keistų pojūčių iš savo kūno vidaus, pvz. elektros srovės, degimo pojūčio, organų didėjimo ar susitraukimo, ar kokių nors kitų pojūčių?*

Taip □ Ne □

kokius pojūčius konkrečiai Jūs jautėte?