A POSITION STATEMENT ON RELIGIOUS DELUSIONS AND HALLUCINATIONS

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When does a religious belief become pathological? A central concern of cultural psychiatry is the differentiation of religious beliefs from psychopathology. The term psychosis has widespread currency in the psychiatric and psychological literature and generally implies some 'loss of contact' with reality. It is characterized by the presence of 'delusions' and 'hallucinations'. To make such a diagnosis mental health professionals make a judgment about the patient's experience in relation to what is defined as 'empirical reality'- something that is not always possible. For instance in paranoid delusions the health professional will occasionally encounter situations when he or she considers the possibility of persecution highly unlikely but lacks sufficient evidence to prove this.

According to the *DSM IV* a delusion is:

A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusional conviction occurs on a continuum and can sometimes be inferred from an individual's behavior. It is often difficult to distinguish between a delusion and an

overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion). (p 765)

Rather than emphasizing falsity of belief which in some cases is impossible to verify beyond doubt, recent approaches to delusional thinking have focused upon other measurable and distinct dimensions of delusions such as conviction, preoccupation, negative affect (emotional distress), and extension (the degree to which the delusion affects one's life). From this perspective delusions are not viewed as categorical but rather as on a continuum with 'normal' beliefs. It is not necessarily the content, but rather the conviction and the efforts made to communicate it which result in distress and is the focus of clinical involvement.

The criterion of falsifiability clearly cannot be applied to beliefs which are non-empirical and this particularly applies to religious/spiritual beliefs. Unlike non-religious delusions which are potentially amenable to reality testing, this is not the case for religious beliefs which are super empirical and empirically unfalsifiable. Rather, for religious beliefs, it is the degree of acceptance by the religious community which can be substituted for falsifiability. A proponent of this view is Pierre (2001) who asserts that a religious belief's dimensional characteristics, its cultural influences, and its impact on functioning may be more important considerations in clinical practice. I concur with this assertion.

Similar issues arise in defining hallucinations. According to the *Oxford English Dictionary* an hallucination refers to 'The apparent perception (usually by sight or by hearing) of an external object when no such object is actually present'. Like

delusions, in order to classify an experience as an hallucination requires that someone other than the percipient make a judgment about their perceptual experience in terms of its fit with reality. The term is associated with value judgments about what is real and what it is possible to know (see Wiebe 1997: 195 for a detailed discussion). Like delusions, Wiebe (2004) proposes that perceptual experience might lie on a continuum and hallucinatoriness might occur in degrees. This is well illustrated by 'normal hallucinations'. There is emerging evidence that 'hearing voices' occurs in the non-psychiatric general population (Romme and Escher 1989, Tien 1991, Poulton et al 2000) which renders the distinction between pathological hallucinations and normal experience somewhat blurred. Religious hallucinations are not amenable to empirical validation, and like religious delusions, their clinical importance must be assessed by the distress associated with them, their effects on functioning and the degree to which they are accepted by members of a specific religious community.

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