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Religious affiliation and psychiatric diagnosis: The influence of Christian sect membership on diagnosis distribution

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Abstract. Minority religions, sects and cults are an increasingly common socio-cultural phenomenon, of which the effects concerning mental health and illness are still poorly understood. In the present study, we compared socio-demographical and clinical characteristics between members of Christian sects and the remaining general inpatient population admitted to a psychiatric clinic in Germany between 1978 and 1991. In comparison to the general patient population, Christian sect patients presented significantly more frequently with a diagnosis of functional psychoses ($P < 0.02$) and less frequently with diagnoses of neuroses ($P < 0.10$). Dissimilarities among sub-cultural groups in help-seeking behavior are suggested to explain the heterogeneous diagnoses distribution found in the study.

Key words: Religion – Sects – Culture – Psychiatric diagnosis

Introduction

In recent years, epidemiological research has demonstrated that social factors such as socio-economic status, ethnicity and cultural background are important variables in the determination of differential prevalence of many psychiatric disorders (Leff 1988; Dohrenwend 1990; Sashidharan 1992).

Although religion plays a central role in socio-cultural life and for most people remains an important dimension of personal experience, it has often been neglected in mental health surveys (Larson et al. 1986).

In 1983, Berguin reviewed the literature on religion and mental health and concluded that religious membership tended to correlate positively with mental health status (Berguin 1983). Recently, Larson and colleagues (1992) made an extensive review of the literature related to religious commitment. They found that religious commitment frequently correlates positively with mental health, although it may have a harmful effect in sporadic cases.

Religion affiliation has not only been related to the prevalence of mental disorders but appears to influence the mental care process itself. For example, controlled studies have demonstrated that religious affiliation significantly regulates the use of mental health services (Schiller and Levin 1988; Larson et al. 1989) and in some cases, probably influences the length of hospital stay (Bourgeois et al. 1975; Dalgalarrondo and Gattaz 1992).

Minority religions, sects and cults are an increasing socio-cultural phenomenon, whose effects on mental health and illness are still poorly understood. Systematic research on this area has only recently begun to be addressed (Galanter 1982). Both protective (Deutsch 1975; Galanter et al. 1979) and adverse effects (Alonson and Jeffrey 1988; Klosinski 1990) have been reported.

Christian sects: definition and recent development

There is some controversy on the precise definition of a religious sect (Reimer 1988). Most religion sociologists would accept the definition of a sect as a voluntary society of strict believers who live apart form the world in some way (Wilson 1968). Sects generally arise in opposition to the accommodation of churches, in rejection of some aspects of their socio-cultural and religious milieu (O'Dea 1968).

Most Christian sects (e.g. Pentecostal Churches, New Apostolic Church, Jehova's Witness etc.) originated in the last 100 years from schisms of the dominant Christian churches (Catholics and traditional Protestants) (Gasper et al. 1990). Charismatic evangelical sects almost always have the following common characteristics (Wilson 1959, 1968; O'Dea 1968, Rolim 1985).

- membership is generally not based on birth, but it tends to be based on conversion or a progressive, and, finally, acceptance of a doctrine;

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Table 1. Evolution of religion membership (%) in West Germany from 1950 to 1987. Source: Statistisches Bundesamt (1991)

	Lutheran	Catholic	Christian sects	No religion
1950	51.5	44.3	0.1	3.7
1961	51.1	44.1	0.4	2.8
1970	49.0	44.6	1.3	3.9
1987	41.6	42.9	2.0	8.0

- the sect is generally a small group, with a high level of lay participation that tends to be hostile or indifferent to secular society and to the state;
- exclusiveness is emphasized, so that sect members tend to view themselves as elects. This attitude facilitates members to tolerate the spirit of austerity and asceticism, frequent in sects;
- sects tend to have a totalitarian rather than a segmental hold over their members, dictating the member's ideological orientation to secular society;
- a charismatic leader is frequently present, exerting great influence on the members;
- most of the Christian sects believe in Christ's return, which is associated with the conviction that the world's end is near and only believers will be saved;
- Puritansim (for example, alcohol, drugs, and homosexuality are often strictly forbidden);
- sects are generally a lower-class religious-cultural protest phenomenon (with exception of gnostic or mystical sects, which tend to attract middle- and upper middle-class people).

Charismatic Christian sects have shown a sound expansion in the last decades (Reimer 1988; Gasper et al. 1990). In Germany, membership in the two traditional Christian churches (Catholic and Lutheran) decreased from 95.8% to 84.5% during 1950–1987, while it increased in Christian sects from 0.1% to circa 2.0% during the same time period (Statistisches Bundesamt 1991) (Table 1).

Psychiatric diagnosis and mental health status among sect members

Clinically based studies

Although scarce, the available studies based on clinical samples have shown that sect members tend to be over-represented in the groups with a diagnosis of "psychosis" (Table 2).

In the psychiatric hospitals of West Australia, Spencer (1975) reviewed 7.546 subjects admitted from 1971 to 1973. He found that members of the "Jehovah's Witness" sect ($N = 50$) were three-fold over-represented within the schizophrenic group.

Jilek-Aall and colleagues (1978) investigated in the upper Fraser Valley of British Columbia, Canada, the diagnosis distribution of patients of three cultural groups ("Native Catholic Canadians", "Doukhobors" and "Mennonites"; $N = 286$) attended by the only two psychiatrists of that region in the years 1966–1974. They found a relative over-representation of schizophrenia among the "Doukhobors" (a religious sect of Russian background) ($N = 23$), of affective psychosis for the Mennonite patients (a puritan sect of German origin) ($N = 163$), and of reactive neurotic depression among the Catholics ($N = 100$).

MacDonald and Luckett (1983) studied a population of 7,050 patients of a mid-western community mental health center in USA. They described the group of Christian sect members (Christian Science, Jehovah's Witnesses, Church of the Latter-Day Saints, Seventh-Day Adventist) ($N = 61$) as having a significantly greater frequency of diagnoses of psychoses than the general population of the mental health center they studied.

In the field of Judaism, Witztum and colleagues (1990a) compared the diagnosis distribution between 71 members of an ultra-orthodox group, the "Baalei Teshuva", and the remaining outpatient population in a Jerusalem mental health center. They found that among the "Baalei Teshuva" the diagnosis of schizophrenia and affective disorders predominate in relation to less severe disorders such as adjustment and neurotic disorders.

Table 2. Diagnosis distribution among religious sects in clinical samples

Author (year)	Country	(N) and religious group	Results
Spencer (1975)	Australia	50 Jehovah's Witnesses among 7,546 inpatients	Jehovah's Witness members were three-fold over-represented within the schizophrenic group
Jilek-Aall et al. (1978)	Canada	23 Doukhobors and 163 Mennonites among 286 outpatients	Over-representation of schizophrenia among the Doukhobors and of affective psychosis among the Mennonites
MacDonald and Luckett (1983)	USA	61 sect members (Christian Science, Jehovah's Witness, Mormones, Adventists) among 7,050 outpatients	Higher frequency of diagnosis of "psychosis"
Witztum et al. (1990a)	Israel	71 Baalei Teshuva members (Ultra-orthodox Jews) among 561 outpatients	Higher frequency of diagnosis of schizophrenia and affective disorders
Witztum et al. (1990b)	Israel	19 Hasadic Sect members among 262 outpatients	Over-representation of schizophrenia, schizo-affective and personality disorders
Dalgalarrondo (1993)	Brazil	27 Pentecostal Church members among 131 acute inpatients	Over-representation of functional psychoses

Witztum et al. (1990b) reported an over-representation of schizophrenia, schizoaffective disorder and personality disorder and an under-representation of neurotic disorders among 19 cases of members of the small Hasidic sect in comparison with 262 outpatients.

Recently, Dalgalarrondo and colleagues (1993) investigated the diagnoses distribution of a sample of 131 acute inpatients admitted to a general hospital psychiatric unit in Brazil. They found that patients who were members of Pentecostal churches ($N = 27$) had a diagnosis of a functional psychosis significantly more frequently.

Although most of these studies have some methodological shortcomings (for example, some of them fail to use objective diagnostic criteria and no one controlled variables such as socio-economic status and educational level), the findings suggest that, in clinical samples, sect members tend to be concentrated in the groups with a diagnosis of psychosis.

Field and ethnographic studies

As clinical samples are usually biased by selection factors, field samples may better indicate the real prevalence of mental disorders among members of religious sects. Unfortunately, there are few studies in the area, and only two of them used a control group of members of major churches (Table 3).

Levine (1973) extensively interviewed 106 young members of sects of Christian and Eastern origin in Toronto, Boston and Montreal. Although he did not use quantitative scales, his overall impression was that *"a significant number of the members could have been described before their conversion as neurotically anxious, depressed, or less frequently, as having a borderline personality"*. He pointed out that he could not find any overtly psychotic subject in this group. According to him, even if a disproportionate number were manifesting psychiatric symptoms, psychiatric diagnoses could not be applied in the majority of cases. However, most reported feeling unhappy and alienated before they jointed the religious cult.

In a carefully controlled epidemiological study in New York, Garrison (1974) investigated a representative sample of 414 Puerto Ricans. She found that the Pentecostal sub-group ($N = 77$), when compared to a random sample of 82 Catholics, matched for socio-economic status, had a lower rate of psychiatric treatments. Moreover, based on the Cornell Medical Index, the author demonstrated that the Pentecostals showed significantly lower levels of psychiatric symptoms.

Tavares de Lacerda (1992), by means of "participant observation", investigated coping strategies for mental disorders among members of a Pentecostal Church in a shanty town in Rio de Janeiro. Although the author did not present quantitative data, her overall impression was that, for most subjects interviewed, Pentecostal membership "buffered" psycho-social stress arising from recent urbanization and poverty.

Galanter and Buckley (1978) investigated 119 members of the "Divine Light Mission" using a multiple-choice questionnaire. Although they found that before joining the sect there was a high incidence of both seeking professional help for psychiatric disturbance (38%), and hospitalization for emotional problems (9%), a symptom decline was found to correlate significantly with group-related activities and attitudes.

In order to investigate 237 members of the "Unification Church" (the "Moonies") in a similar way, Galanter (1979) used a 216-item structured questionnaire. It included questions relative to pre- and post-conversion phases. The authors reported that members experienced a fair amount of psychological difficulty before joining the church. Thirty nine per cent felt that they had had serious emotional problems in the past, 30% had used professional help for this kind of problem, 23% admitted they had had serious drug problems in the past and 6% had been hospitalized because of "emotional" disturbances. The authors concluded that affiliation to that sect apparently provided considerable and sustained relief from neurotic distress. A greater religious commitment was reported by those who indicated the most improvement.

The same author (Galanter 1986) conducted a 3-year follow-up study with 305 members of the "Unification

Table 3. Diagnosis distribution among religious sects in field studies

Author (year)	(*N*) and religious group	Results
Levine (1973)	106 adolescent members of Christian and easter derived sects	Before the conversion, many subjects wre anxious, depressed or borderline
Garrison (1974)	77 Pentecostals compared to 82 Catholics from the same socio-economic status group	Pentecostals had significantly lower levels of psychiatric symptoms compared to Catholics
Galanter and Buckley (1978)	119 members of the Divine Light Mission	High frequency of "emotional problems" and mental health professionals seeking before conversion into the sect
Galanter et al. (1979)	237 members of the Unification Church (The "Moonies")	High frequency of "emotional problems" and mental health professionals seeking before conversion into the sect
Caetano and Herd (1984)	178 members of Fundamentalist Churches	Fundamentalist Church membership was a protection factor against alcohol abuse
Galanter et al. (1986)	305 members of the Unification Church	Lower psychological well-being score in comparison to the general population

Church". He found that 95% remained active in the church and 85% had been married in the meantime to mates designated by their religious leader. Throughout the study, the group remained with a significantly lower psychological well-being score (assessed with the General Well-Being Schedule) in comparison to the general population, and members who deviated from the sect's expectations showed even greater distress.

Caetano and Herd (1984) conducted an extensive community survey in the San Francisco Bay area, aiming to identify risk factors relative to alcohol disorders among black Americans. From an original sample of 4,150 adults, 1,206 identified themselves as blacks. The authors found that those who belonged to a fundamentalist religious group were significantly more often abstainers and light drinkers than those who belonged to major religious groups. This well-conducted study seems to indicate that fundamentalist sects may represent a protective factor related to alcohol disorders.

In summary, field and ethnographic studies have indicated that sect members are people that, at least before entering the sect, appear to have more psycho-social distress, anxiety and drug problems. Nevertheless, a study with a better epidemiological methodology (Garrison 1974) did not find higher psychiatric morbidity among sect members. There are some indications that affiliation to a sect may exert a protective effect, at least for those who remain in the sect and observe its values and habits.

Patients and methods

To examine the relation between Christian sect membership and diagnosis distribution, we compared socio-demographical and clinical data of two groups of patients (Christian sect members and the remaining inpatient population) admitted to the Psychiatric Clinic of the Central Institute of Mental Health Mannheim between 1978 and 1991.

The Psychiatric Clinic of the Central Institute of Mental Health (CIMH) Mannheim has 110 beds. It is a public university facility that predominantly admits patients from a catchment area of 500,000 people.

Data of all patients ($N = 9{,}057$) admitted to the clinic between 1978 and 1991 were reviewed.

Clinical diagnoses were made according to the International Classification of Diseases (ICD-8 and ICD-9) of the WHO.

Socio-demographical (age, gender, marital status, educational level, occupational status, insurance coverage and socio-economic status) and clinical data (clinical diagnosis, duration of illness, duration between onset of first symptoms and first treatment, number of previous admissions to the clinic, length of hospital stay and global improvement at discharge) were obtained from the medical chart by means of a computed system of medical documentation.

For the purposes of this study, the independent variable was "religious affiliation". In our system of documentation, the alternatives for religious affiliation were:

1. Catholic
2. Lutheran Protestant
3. Christian sects
4. Greek Orthodox
5. Muslim
6. Jew
7. Other
8. No religion

The group "Christian sects" was compared to the general patient population of the clinic, which means the remaining religious groups and the "no religion" group.

For statistical analysis of categorical data, we used the chi-square test, and, for continuous variables, Student's two-sample *t*-test and Sheffe's test.

Results

From 1978 to 1991, 9,057 patients were treated in the psychiatric clinic of the CIMH Mannheim. In this group, the most frequent religious groups were Lutherans ($N = 3{,}623$; 40.0%) and Catholics ($N = 3{,}378$; 37.3%). In this period, 103 patients (1.1%) from the group "Christian sects" were treated in the clinic. The distribution of all religious groups in the clinic, compared to distribution in the district of Mannheim, and in Germany are seen in Table 4. The specific religious sects comprised in the study were the following: New Apostolic Church (32%), Jehovah's Witnesses (20%), Baptists (10%), Adventists (8%), Pentecostals (6%), Old Catholic Church (6%) and others (18%).

There were no significant differences between the groups in age, gender, marital status, occupational status, duration of illness, length of hospital stay and global improvement (Table 5).

Social-economical status was classified in two levels, high-medium and low, according to income and professional status of the family head. Although differences between the two groups did not reach statistical significance, there was a slight tendency to lower social class among sect members, as 64.7% of them were in the lower group, against 51.8% in the general group ($\chi^2 = 2.15$, $df = 1$, $P < 0.15$) (Table 5).

In the Christian sect group, patients had less private insurance coverage than in the general group [1.9% ($N = 2$) had this form of insurance against 11.2% ($N =$

Table 4. Religion membership distribution in the clinical sample (1978–1991) of the psychiatric clinic of the Central Institute of Mental Health Mannheim, in the district of Mannheim (1987) and in West Germany (1987)

Religious group	Clinical sample N (%)	Mannheim (%)	West Germany (%)
Lutheran	3,623 (40.0)	38.2	41.6
Catholic	3,378 (37.3)	38.9	42.9
Muslim	163 (1.8)	5.6	2.7
Christian sects	103 (1.1)	1.5	2.0
Greek Orthodox	54 (0.6)	[a]	[a]
Jew	18 (0.2)	[a]	0.1
Other	54 (0.6)	15.8	2.7
No religion	697 (7.7)	[a]	8.0
Missings	969 (10.7)	–	–
Total	9,057 (100)	100	100

Sources: Data for Mannheim; Amt für Stadtentwicklung und Statistik Stadt Mannheim (1988). Data for West Germany; Statistisches Bundesamt (1991). [a] No data available

Table 5. Demographic characteristics of "Christian sects" group and the "general patient group", in the psychiatric clinic of the Central Institute of Mental Health Mannheim (1978–1991)

	Christian sects	General patient group
N	103 (1.1%)	8,954 (98.9%)
Age (years)	41.2 ± 17.8	43.2 ± 17.9
Gender (% women)	58.7	58.4
With marital relationship	42 (40.4%)	3,700 (41.4%)
With employment	32 (30.8%)	3,080 (34.9%)
Lower social class	44 (64.7%)	2,947 (51.8%)
Private insurance	2 (1.9%)	1,027 (11.2%)**
Successful graduation ("Abitur")	10 (9.6%)	1,408 (16.4%)[t]
Special school in childhood	6 (5.8%)	154 (1.8%)*
Technical college frequency	2 (1.9%)	728 (8.3%)*

[t] $P < 0.10$; * $P < 0.05$; ** $P < 0.01$

Table 6. Distribution of diagnosis and religious affiliation in the psychiatric clinic of the Central Institute of Mental Health Mannheim (1978–1991)

	Christian sects	General patient group
Functional psychoses (ICD 295–299)	55 (52.9)	3,375 (37.7)*
Neuroses and personality disorders (ICD 300–302, 306–309)	31 (29.8)	3,656 (40.8)[t]
Psycho-organic syndromes (ICD 290, 293–294)	5 (4.8)	890 (9.9)
Alcohol-related disorders (ICD 291–292, 303–305)	7 (6.7)	705 (7.9)
Mental retardation (ICD 310–315, 317–319)	0 (0)	125 (1.4)
No diagnosis	6 (5.8)	202 (2.3)*

[t] $P < 0.10$; * $P < 0.02$

1,027) in the general group ($\chi^2 = 8.25$, $df = 1$, $P < 0.01$) (Table 5)].

Patients from the Christian sect group had a lower educational level. Only 1.9% ($N = 2$) of them had studied in a technical college (Fachhochschule in the German system) against 8.3% ($N = 728$) in the general group ($P < 0.05$), and only 9.6% ($N = 10$) of them succeeded in the German high school examination (Abitur) against 16.4% ($N = 1{,}408$) in the "general patient group" ($P < 0.10$) (Table 5). Members of "Christian sects" had visited a special school for disabled children, during their childhood, (5.8%, $N = 6$) more frequently than members of the "general patient group" (1.8%, $N = 154$) ($\chi^2 = 8.71$, $df = 1$, $P < 0.01$). Even though these variables were controlled for diagnosis, the significant difference remained.

In relation to the "general patient group" (GPG), "Christian sect patients (CSP) presented more frequently with a diagnosis of functional psychoses (ICD 295–299) (CSP, $N = 55$, 52.9%) (GPG, $N = 3375$, 37.7%) ($P < 0.02$) and a tendency to less frequent diagnoses of

Table 7. Clinical characteristics of "Christian sects" group and the "general patient group", in the psychiatric clinic of the Central Institute of Mental Health Mannheim (1978–1991)

	Christian sects	General patient group
Duration of illness (years)	6.2 ± 7.8	5.7 ± 8.0
Duration between onset of first symptoms and first psychiatric treatment (years)	0.7 ± 2.1	1.3 ± 4.0** [a]
Duration of hospitalization (days)	41.2 ± 42.5	39.1 ± 41.4
Patients with global improvement after treatment	33 (30.8%)	2,742 (30.0%)
Number of previous hospital admissions	2.9 ± 2.8	1.7 ± 1.7*** [b]

** $P < 0.01$; *** $P < 0.001$

[a] Difference disappeared after controlling for diagnosis

[b] Difference remained highly significant ($P < 0.001$) even after controlling for diagnosis

neuroses (CD 300–302, 306–309) (CSP, $N = 31$, 29.8% and GPG, $N = 3656$, 40.8%) ($P < 0.10$). There were no statistically significant differences between the two groups with respect to frequency of diagnosis of psycho-organic disorders, alcohol and drug dependence, and mental deficiency (CD 290, 293–294, 291–292, 303–305, 310–315, 317–319) (Table 6).

Although sect member patients had a significantly shorter duration between onset of first symptoms and first treatment (CSP = 0.68 + 2.13 years; GPG = 1.31 + 4.03 years; $P < 0.0001$), this differences disappeared when controlling this variable for clinical diagnosis through Scheffe's test.

Sect member patients had significantly previous admissions to the clinic (CSP = 2.87 ± 2.83; GPG = 1.71 ± 1.70; $P < 0.001$). Even though this variable was controlled for clinical diagnosis, the difference remained strongly significant ($P < 0.001$) (Table 7).

Discussion

Although it is wise to refrain from drawing firm conclusions on the basis of clincial samples (because of the selection effects), it should nonetheless be noted that this procedure may be the only way to collect a sample of sect members with psychiatric disorders large enough to compare them with patient members of major denominations. We must therefore consider these possible selection effects when formulating the explanatory hypotheses. Moreover, grouping different Christian sects into a single group may be considered problematic. Nevertheless, we consider this procedure valid, because the differences amog these sects reside much more on theological than on sociological aspects. Sociologically, according to prominent religion sociologists (Wilson 1959, 1968; O'Dea 1968) they represent a group with a common socio-cultural profile.

Although we found only a trend toward lower socio-economic status in the sect members, the fact that they

have significantly less private insurance indicates that they might belong to a lower socio-economic status group.

Patients from the sects group had lower educational level (less successful "Abitur", less technical college frequency and more special classes). It is well-established from sociological studies that low socio-economic status correlated well with low educational level (Hodge and Siegel, 1968). Thus, it is likely that the significant lower educational level found in the sect group is a result of their tendency to lower socio economic status.

The distribution of the diagnoses was clearly different between sect members and the remaining inpatient population. In the former, there was a significant over-representation of functional psychoses and a tendency to under-representation of neuroses. Even controlling this profile for educational level, this difference remained significant. Thus, it is unlikely that the difference in diagnoses distribution between the religious groups is due to differences in educational level or socio-economic status. Moreover, the higher number of previous hospitalizations in the sect group indicates that this group indeed comprised much more severe patients.

The results of the present study are in line with previous research in this area that indicated that, in clinical samples, sect members tend to be concentrated in the group with a diagnosis of psychosis.

Some different interpretations can account for this over-representation. On the one hand, the data may suggest either that sect membership is a risk factor predisposing to psychotic breakdown, or that pre-psychotic (or even psychotic) subjects are more likely to join a religious sect. The results of the field studies formerly reviewed raise doubts about this hypothesis. Although some of these studies pointed out to higher unspecific psychiatric morbidity, no one found a higher real prevalence of psychosis among sect members.

On the other hand, supporting an alternative hypothesis related to health care-seeking behavior, there is evidence that religious affiliation strongly influences the use of mental health services (Larson et al. 1989). Lin and colleagues (1978) demonstrated that groups that do not ascribe to the norms and prevailing values of a society will only refer their most severe cases to the official medical establishment. Furthermore, affiliation to a sect often entails rejection to secular society and of psychological explanations of mental disorders (Witztum 1990). McLatchie and Draguns (1984) have shown empirically how members of evangelical sects prefer religious advisers to mental health professionals in addressing their emotional problems. Sect members with neurotic disorders might be retained in the church, and only the members with severer disorders (e.g. psychoses) are sent to the official medicine.

Field studies could shed some light on this issue. Ideally, controlled epidemiological data (based on groups matched for age, gender, socio-economic status and cultural background) should be combined with a careful qualitative ethnographic approach (which must consider not only religious affiliation but also intensity and other dimensions of the religious phenomena). Such a combined approach should provide a better understanding of the complex relationship between mental illness and membership in religious sects.

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