

RELIGIOUS BELIEF AND THE PRACTICE OF PSYCHIATRY

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Abstract: A psychiatrist reflects upon his long experience of the complex interaction between religion and psychiatry. Although committed to the advances wrought by the bio medical approach to illness, he identifies a widespread neglect of the Spiritual in mental health care, which belies its claim to be truly holistic. The article discusses the concept of spiritual illness and the limits of psychiatry, and then poses the question whether religious belief is good for a person's mental health. In his conclusion the author, himself a Christian, underlines the need for psychiatry to have the fullest possible understanding of the patient's world view, and that this will necessarily involve a consideration of the importance of the Spiritual.
The editors

Key words : mental health; spirituality; religion; psychiatry; spiritual illness.

Introduction

This article comprises a personal reflection rather than a scientific study. I have worked as a psychiatrist in the NHS for 19 years and for 13 years as a consultant. In this article I will reflect on three areas on which I have often been questioned during this time. The first concerns the role of spiritual factors in mental health care, more specifically the neglect of the spiritual, and the common reluctance of mental health professionals to enter into discussion on spiritual aspects of their patients' lives.

Secondly, I consider the limits of psychiatry in dealing with problems with a spiritual aspect to them. Does 'spiritual illness' exist, and is it separate from 'mental illness', or is this an oversimplification of the complexities of human experience? Is the realm of the spiritual significant, and does its neglect highlight the limitations of bio-medical or psychological approaches to people?

The third area relates to the debate around whether religious beliefs are a help or a hindrance in terms of mental health. I review some positive and negative aspects of the relationship between the two.

At the outset of an article like this it is important to be upfront about one's own stance and I make it clear that I write from a Christian perspective. I do this to highlight the fact that our own personal world view clearly influences who we are and how we

behave even in the clinical setting. We bring the assumptions and prejudices of our own position into this arena as much as to any other. This is true of those of all religious beliefs and those with none. To deny this is to be dishonest with our patients and ourselves. The idea of the neutral "blank screen" therapist is in my view a myth. It is never the role of the psychiatrist to impose his or her world view on the patient but this does not mean that world view has no impact on the therapeutic relationship.

1.Spiritual factors in mental health care.

Larson(1986) writing from an American perspective has highlighted that religious belief in the general population is more prevalent than it is amongst mental health professionals, but does this matter? Larson argues that it may well as studies indicate that religious belief influences contact with psychiatric professionals in a number of ways and in particular that "those with more conservative Protestant beliefs attempt to find a therapist with parallel beliefs". Lest we are tempted to think of this as an exclusively US phenomenon Faulkner(1997) reporting a Mental Health Foundation study in the UK states that over 50% of service users hold valued religious or spiritual beliefs which they regard as helping them to cope but which they feel restrained in talking about with their psychiatrist.

These things resonate with my own experience. Firstly I have no doubt that conservative Christians have sought me out as a psychiatrist. The reasons are various and by no means all healthy. Many have an understandable but usually ill founded fear that secular psychiatrists will ridicule or undermine their faith. Others mistakenly equate "Christian psychiatrist" with "better psychiatrist". Worst of all are the minority of Christian patients who want to see a Christian psychiatrist not to receive treatment but to have an authoritative figure collude with them in spiritualizing a problem rather than facing up to it in an honest way.

Second, there seems little doubt that mental health professionals of all hues ignore or underestimate the importance of spiritual factors in patient care as has been cogently argued by Sims (1994) and Nolan and Crawford(1997).

The neglect of the spiritual in mental health care

Both Sims and Nolan and Crawford have attempted to define what is meant by the word "spiritual" in this context, and for a more detailed discussion of this the interested reader is referred to these authors. Common to the definition of both authors are:
aspects of relating to oneself
relating to others including social awareness
relating to "that which is transcendent" or to God

Sims also adds a moral dimension to his definition. Importantly neither confine the use of the word "spirituality" to adherence to any organized religion, both seeing it as much broader than that.

These authors also discuss the reasons why mental health professionals shy away from discussion of spiritual aspects of their patients lives, these include:
they think it is unimportant
they think it isn't relevant to psychiatry
they know little about it
they are embarrassed
the effects of a secular bio-medical approach to medicine

In considering religious and spiritual variables as unimportant we are simply wrong. Based on the surveys quoted above Larsen writes "the general public appears to value religion as a major factor in their lives whereas, in general, mental health professionals do not". Our lack of knowledge of these ar-

eaas and our embarrassment in speaking about them (most mental health professionals would struggle more discussing spiritual issues or personal religious faith with a patient than for example discussing intimate sexual issues) is surely a matter for concern and for education and training(Nolan and Crawford op cit).

For all the magnificent and admirable advances wrought by bio-medical approaches to illness surely one of its dangers is that it may de-humanise medicine in general and psychiatry in particular, though this should not be inevitable. Blazer (1998) an eminent academic psychiatrist in the USA who is also a professing Christian, writes in confessional mode:

"I have necessarily changed my practice style over the past twenty five years. I have become a better doctor in many ways" but..." the changes(wrought by advances in biological psychiatry-my italics) described above have prevented me from entering into relationships that are not therapeutic and encouraged me to use medications often with dramatic results when listening and talking are to no avail. Yet I believe my patients and I have lost as much as we have gained. I don't know them and they don't know me and psychiatry frankly is less rewarding. I have withdrawn my soul in large measure from my practice"

The neglect of the spiritual in psychiatry is made worse by the fact that psychiatry is a medical specialty which frequently parades its "holistic approach" often in a self righteous manner critical of other disciplines.

Nolan and Crawford have cogently argued (in the context of psychiatric nursing) that recognizing the spiritual is central to our understanding of the meanings our patients attach to their lives and that only by doing this can we begin to understand their suffering.

2.The limits of psychiatry

In her letter inviting me to contribute this article the editor asked me if "I would allow that there is such a thing as spiritual illness as well as mental illness?" The short answer is that I would, but in reality the answer is not so straightforward. In my thinking as a psychiatrist I would try not to categorise things as "spiritual" or "mental" or even as "physical" or "mental". Such distinctions inevitably oversimplify

matters. Malcolm Jeeves(1977), a retired professor of psychology argues powerfully against what he calls “nothing buttery”. This is the tendency to a reductionist one dimensional view of things. A world view which reduces complexity to a simple rather naïve view of things e.g. “man is merely a collection of atoms and molecules”. Jeeves highlights the fact that things can often be explained on different levels and in different ways and that these are not always mutually exclusive, but can co-exist. This notion is surely relevant in discussing the “spiritual” versus “mental” debate. Even the estimable Donald MacLeod (1988) over simplifies this in his excellent series of articles on religion and mental health. He argues that depression with spiritual causes recurs unless underlying spiritual causes are addressed and whilst this may be true the fact is that most depressive illness recurs. It is simply the nature of the beast. Recurrence per se in no way implies that some underlying “spiritual” problem is being missed, though it is conceded this may sometimes be the case.

All of this notwithstanding it is easy to see where the editor was coming from with her question about “spiritual illness”. There are I think many problems which often present to psychiatrists which seriously highlight the limitations of our approaches to people whether these are pharmacological or psychological.

Nolan and Crawford cite general practitioner James Le Fanu’s experience of trying to deal with alienated young adults in his surgery (Le Fanu 1995). Le Fanu notes that these young people usually reject or fail to respond to traditional psychiatric approaches (drugs or psychotherapies). He conceptualizes these people as “spiritually ill” and Nolan and Crawford question whether they are likely to be helped by “a health service that prefers patients to have diagnoses so it can more easily justify its allocation of resources to deserving cases”. Whilst I remain committed to these traditional psychiatric approaches (because I would argue they do help a considerable number of people) it is difficult not to see that both Le Fanu and Nolan and Crawford have a reasonable case. I have frequently as a psychiatrist found myself in my day to day clinical work in situations where psychiatry fails individuals because it has nothing to say to their situation and no answer to their problems. Take for example the person consumed with envy or bitterness who will not let go of their anger or hatred of another. What has the psychiatrist to offer? Barker

(2000) writing from an overtly Christian perspective states that often “forgiveness is essential to the true healing of relationships “. This, he argues, is what psychotherapy (or drugs) cannot provide. He further states that forgiveness “has to do with breaking down idealization and recognizing in oneself and others both good and bad and learning to live with that. It comes from an awareness that God loves us in spite of our wrong doings. By alleviating guilt forgiveness can be a most powerful contribution to mental health”. I have on occasion had to gently but firmly to confront patients whose continued poor function in terms of day to day relationships stemmed from bitterness or hatred, with the (for them) uncomfortable fact that unless they can forgive (and if necessary receive forgiveness) they would remain in a prison of their own making. It should be noted that problems of this nature are not confined to those of no religious belief or to those who deny any spiritual aspect to their experience. Such problems are found in those of all religious faiths and those with none.

In summary then, I would as the editor put it “allow” that mental ill health is sometimes complicated by or even caused by , issues which I would contend are “spiritual” (as defined earlier in this article). This is often unacknowledged by psychiatric professionals who often feel safer with reductionist bio-medical or even psychological models of illness and the (sometimes) limited approaches which come with them.

Having stated that these problems are not confined to those who call themselves “religious” I will now discuss whether religiosity confers any benefits on individuals mental health.

3. Is religious belief good for your mental health?

Much has been written on this subject anecdotally, e.g. MacLeod (1988), but over the last 3 decades there has been a burgeoning of the literature on this subject. The scientific literature comes with two caveats. Firstly it is largely from the United States, and secondly it is mostly about Christianity and Judaism, with little or nothing about other religions. This literature has been summarized recently by Barker (2000). Barker cites Larson (1992) who has carried out several important studies in this area. Larson reviewed a considerable number of variables and measures of religious commitment and their

contribution to mental health. The measured variables which conferred most benefit were, attending religious services, prayer, social support (within a religious body) and perceived relationship with God.

Schumaker (1992) edited a review of the literature and mental health and concludes that religious belief reduced “existential anxiety” and conferred hope and meaning.

Negative aspects of religious belief and mental health include occurrence of inappropriate guilt, low self-esteem, self denigration, unhealthy denial of anger, dependency and sexual maladjustment. The reasons for some of this have been expanded by McCandless (1982) who from a Christian perspective notes the “danger of equating Christian commitment with a denial of one’s humanity”. Barker, himself a Christian, acknowledges that certain Christian teachings are “damaging to certain personalities” but goes on to “dispute the view that equates mental health with self sufficiency, letting it all hang out, and with freedom to experiment sexually, homosexually, heterosexually, pre and post maritaly; and suggests that to have problems in these areas indicates poor mental health”.

Barker summarizing the literature concludes that religious commitment usually has positive benefits on mental (and indeed physical) health. He summarises the most strongly positive factors in the Larson study, i.e. attending services, prayer, social support and perceived relationship with God, as “believing and belonging” and concludes this confers most benefit.

It is not to be concluded from this that religious believers are somehow immune from mental illness. They are not and in this regard the facile teaching of some conservative Christian groups that “just a little talk with Jesus makes it right” is frankly dangerous. Fortunately in my experience this overly simple notion that by adhering to Christian beliefs you somehow be spared “the slings and arrows of outrageous fortune” is increasingly rarely taught.

There is some evidence from the literature that the mentally ill are found in larger numbers in churches (Sims). The evidence suggests that it should not be concluded that attending church is a risk factor for becoming mentally ill. The explanation is rather one of “social drift” i.e. the mentally ill drift towards

churches because they find them helpful and supportive. Anecdotally the author has experienced huge variation in attitudes to mental illness and to the mentally ill within churches. Some are exemplary in the care and support they provide whilst at the other extreme some go so far as to deny the existence of mental disorder seeing all such problems as “spiritual”.

Summarising then, certainly for Judaeo – Christian religions, it appears that religious belief usually confers mental health benefits and certainly does not cause increased rates of mental illness. It does not however confer immunity to mental illness.

Conclusions:

I have used this article to reflect on three areas on which I have often been questioned over the last two decades during which time I have worked in psychiatry as a person with Christian beliefs. These concern the role of the “spiritual” in mental health, the limits of psychiatry in addressing spiritual issues and the relationship between religious belief and mental health. I am aware that I have probably raised more questions rather than supplying answers to those asked of me.

My experience leads me to conclude that whilst most mental health practitioners are not overtly hostile to religious beliefs, most underestimate the importance of these beliefs to a significant number of their patients. It is good psychiatric practice to achieve as full an understanding as one can of a patient’s world view, religious or otherwise. More attention ought to be given to this in the training of psychiatrists and other mental health professionals. Further the psychiatrist ought to be aware of how their own world view may influence their approach to patients and this issue should routinely be discussed in supervision.

Further, mental health practitioners should avoid adopting preconceived ideas about the attitude of religious believers to psychiatry. In reality these are very variable even sometimes within the same broad religious group. As an extension of this it needs to be recognised, as argued above that there are aspects of religious belief (and of religious organisations) which can be of value in terms of improving mental health.

During my time in psychiatry, I have worked daily with extremely ill people whose quality of life is very poor. Whether this is caused by social deprivation, neglect, spiritual problems or brain disease will continue to be debated. (I would argue all are relevant.) On a personal level I doubt I would have coped so well without a personal faith and relationship with God. This certainly colours my view of all human relationships and hopefully has helped me relate to others, particularly patients, in a way which is healing to them.

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