

ARE PSYCHIATRIC PRECONCEPTIONS AGAINST PASTORAL CARE SCIENTIFICALLY APPROVED?

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Abstract : Clergy and psychiatrists should be natural allies in mental health care. Yet mutual misunderstandings and negative preconceptions remain to be overcome. This article explores some of these misunderstandings and preconceptions as they operate in the field of psychiatry, and suggests ways in which they might be broken down.

Keywords : Spirituality; religion; psychiatry; mental health; pastoral care; therapeutic intervention.

Introduction

Pastoral counsellors and chaplains are very often the first to be asked for help or advice by people who face psychological difficulties. In the USA, according to some studies, one third of the total percentage of individuals referred to psychiatric services had initially sought help from the clergy (Larson 1988). Psychiatrists know that timely recognition of psychopathology and immediate therapeutic intervention aiming to decrease the prevalence of a disease in the total population are basic elements in so called secondary prevention. Consequently, clergy could be of great use in the early recognition of psychopathology and have the potential to be very important co-workers of with mental health professionals. Despite this fact, it seems that some trends and approaches in the field of psychiatry hinder the potentially fruitful contribution of pastoral care in the struggle against psychological suffering. Undoubtedly, the same problem could be investigated by focusing on the religious attitudes concerning psychiatry as well, but in this paper it is the psychiatric side which we are mainly interested in.

The problem of psychiatric prejudices

Given that mental health workers and clergy used to have the same sufferers to look after, it is almost incomprehensible why the cooperation between therapists and pastors is not always as good as it should be.

An explanation usually adopted by psychologists or psychiatrists is that clergy have negative preconceptions against psychiatry, and sometimes this is true. But it is a half truth. The other half concerns the negative preconceptions held by psychiatrists. An inevitable question arises concerning the extent to which these are scientifically supported.

For instance, among many psychiatrists, the received wisdom decrees that religion should be included among the risk factors for psychopathology. Although this old idea is still "in fashion", it has never been confirmed by scientific research. On the contrary, recent studies show strong evidence for a positive role of religious beliefs in mental health ; in reinforcing good health and well-being in older people (Koenig et al 1988); in fostering the ability of some patients to recover from stress caused by burns (Sherrill and Larson 1988); in overcoming the psychological effects of ageing on self-esteem Gutman 1987); in strengthening physically ill individuals (Cassem 1988), and in maintaining low levels of depression in elderly women after surgery for broken hips (Pressman et al 1990). Peterson and Roy include religious faith in a group of so called "comfort beliefs", which relieve and strengthen individuals facing difficult periods in their life (Peterson and Roy 1985).

Psychiatrists are aware that the percentage of suicide attempts is lower among those with religious faith, and that religion contributes positively in recovery

from mourning. Needless to say, there should be no confusion between a healthy faith and the unhealthy religiosity which psychiatrists encounter on occasion with some of their patients.

A very important issue for the patient is to know and understand as much as possible about the nature of his/her problems, so that therapy can be accepted and prove effective. A common idea of therapists is that the psychiatric patient tends to explain his/her problems through religious ideas or preconceptions and that this could hinder his/her compliance to his/her therapy. Because of this, therapists feel inclined to protect their patients from what they consider to be the negative effects of religion; the upshot of this is that they often ignore religious aspects themselves, and encourage the patient to do so as well.

Yet research published by Sheehan and Kroll in the American Journal of psychiatry (1990) advocates quite the opposite of this perceived negative effect of religion upon compliance with therapy. In this study it is shown that 95% of the psychiatric inpatients population declared that they believe in God, but that despite this, 83% considered general health factors as the cause of their illness, while only 23% associated their problems with moral issues, and, even then, not always of religious origin (Sheehan and Kroll 1990). The same investigators had shown in previous studies that the role of guilt in depression has been overestimated (Kroll and Sheehan 1989) and the same is predicated by other research too (Prosen, Clarc and Harrow 1983).

Towards a global therapeutic approach

It could be claimed that the aforementioned studies simply record cultural changes which do not represent a generalised tendency to overcoming previous accepted ways of thinking. Against this point of view can be cited two very interesting papers which debate the conviction that during the Middle Ages the systems of understanding and explaining mental disorders were based mostly on religious ideas or superstitions (Kroll and Bachrach 1984, 1986).

But even if a patient tries to understand his/her illness through his/her religious beliefs what is wrong with that, provided it is not delusional? Shehan and Kroll quote a very interesting comment on this point

"Since humans appear constitutionally designed to seek meanings for the events in their lives or to impose meaning on them, it is not surprising that they will often use a religious framework in this constant endeavour. Providing a meaning for the otherwise incomprehensible circumstances of personal tragedy is one of the major functions, raisons d' être, and appeals of religion. While the neurotransmitter hypothesis regarding the aetiology of depression offers a rational scientific explanation for the occurrence of depression, it does not address the question 'why me?' in the personal terms in which we are accustomed to explain the events of our lives" (Sheehan and Kroll 1990).

The abovementioned examples indicate that we have no right to accept some perceptions as self evident, which reflect mainly ideological rather than scientific values, without any concern about their objectivity.

We shouldn't forget that modern psychiatry declares itself as based on the "psycho-bio-social" model. This theoretical model, representing a modern, widely accepted holistic approach in psychiatry, is a system of hypotheses about the soul and body, the significance of psychosocial factors for health and sickness, and the practical importance of those factors for therapeutic interventions.

In practice it means that when we organise our preventive or therapeutic methods we must be aware of all the psychological, biological and social elements of the human being. Undoubtedly religious faith is one of these elements, as it has always constituted an important, multifaceted psychosocial factor, influencing personality construction and way of living, either directly for the religious or indirectly for almost every one, as it is one of the structural elements of western civilisation.

But if this is such an important aspect, then how can we explain the general, sometimes total, psychiatric lack of interest in religious matters? Larson et al, in a paper published in the American Journal of psychiatry had shown that only 3% of the published papers during a five year period had included among the items they had studied any variables referring to the religious faith of the studied population (Larson et al 1986). This same study and a subsequent one clearly reveal a lack of sensitivity both in the way of understanding and the way of framing questions on

religious matters (Calanter, Larson and Rubenstone 1989). One less standardised but more prolonged study shows to say the least a lack of sufficient information about how to evaluate religious experiences, ideas and feelings either as morbid or of therapeutic value (Pattison 1989). Another indirect indicator of this reduced sensitivity is also shown by the lack of understanding of the methods of and the need for pastoral counselling of some patients (Young and Griffith 1989).

Why does this situation come about, when the need of development of every possible approach to therapy has been acknowledged even in the basic textbooks of psychiatry? Greenblatt, for instance, in a text included in one of the classical textbooks of clinical psychiatry, emphasises that the role of the priest offers an important opportunity for an early intervention to parishioners in crisis and he expresses his certainty that frequent interaction and cooperation between psychiatrists and clergy will improve the quality and quantity of referrals (Greenblatt 1985).

Sometimes this lack of appropriate sensitivity does not result only in the loss of an additional aid in the struggle to provide mental health, but even in some scientific or ethical problems. This is a likely reason why the American «Committee on Religion and Psychiatry» provided particular guidelines regarding possible conflict between psychiatrists' religious commitments and psychiatric practice. The basic ideas of these guidelines are: a) psychiatrists must respect the «beliefs» of their patients, and b) The therapist has no right either to impose his/her personal religious, anti-religious or ideological beliefs or to substitute his/her patient's beliefs with diagnostic values or therapeutic techniques (Guidelines 1990).

Conclusions and proposals

All the aforementioned tend to support the view that the contribution of the clergy to preventive psychiatry could be of great importance. We must emphasise that we do not mean or imply any need for mental health professionals to be religious. We merely want to underline that they have to be real professionals.

Psychiatry must be faithless and irreligious: Faithless in the sense of being without preconceptions

against or for anything, including religion, and irreligious in the sense of not being used, consciously or not, as a religion by replacing spiritual values with its own values, and so becoming a neo-fundamentalist religion itself.

Maybe the first, but vital step for psychiatry is to think about promoting some initiatives in order to facilitate and also take advantage of the ecclesiastical contribution.

The main thrust of those initiatives could be:

- a. Training – education in mental health topics of those in the churches who wish to make a contribution to mental health care.
- b. Reclaiming the structures and resources already existing within the churches, and utilizing these in the service of prevention, therapy and rehabilitation.
- c. Planning some ways to challenge and to overcome negative attitudes on both sides.
- d. Raising awareness among professionals in both psychiatry and religion, during their basic education and training, (medical schools, theological seminaries and so on).

Our experience of cooperation between the psychiatric services and the church in establishing the first boarding house for the rehabilitation of institutionalised psychiatric patients of the Psychiatric Asylum of Leros in Greece permits us to be optimistic (Avgoustidis 2001-2002).

In any case, close and trusting cooperation is absolutely necessary in order to achieve those aims. Otherwise any chance of improvement in psychiatric care will evaporate in the gap opened by the neurotic prejudices coming from both the ministerial and the psychiatric side.

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