

## ORTHODOXY OR HERESY? A NEW WAY OF LOOKING AT SPIRITUAL CARE FOR PEOPLE WITH DELUSIONAL BELIEFS.

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*Abstract: This essay uses this language of theological belief to examine the belief groups within the mental health system. Its purpose is to shed light from one world upon another, to investigate the relationship between chaplains, who think theologically, patients, and the professional members of the mental healthcare field.*

*Key words: Chaplaincy, delusions, mental health, spirituality*

### Systems of Belief

Biblical scholarship has moved a long way since the first studies were made of the emergency of heresy. Since the work of Walter Bauer in the 1930s, the idea that there was some heterogeneous orthodoxy from which heresy was a clear choice of difference in the early church has been supplanted by a picture of complex faith groups adhering to multiple theological stories in which some groups differed sufficiently to adopt that difference as their identity. Put more simply there hasn't always been a right way and a wrong way to believe in Jesus Christ but a rainbow of beliefs which fit into Christianity and then beliefs which have been identified as necessarily sitting outside the Christian faith.

The same is true of all belief. Belief is never fixed and is always complex. It is never easy to categorise nor to define with clarity. Even so, there are general groups of beliefs which can be identified into categories, such as the beliefs of the major religions.

#### Medical Beliefs

It is also generally accepted that medical systems, such as a multi-disciplinary team in a mental health setting, run with accepted values and beliefs which allow membership of the professional group. These beliefs form an identifiable and acceptable method of working and are often, though not always, based on either research or training. Thus it can be the case that occupational therapists and physiotherapists can work with nursing teams sharing the be-

lief that activity and physical fitness are therapeutic and beneficial for patient care, whether or not each nurse within the team agrees that ensuring this to be the case is a nursing responsibility. The psychologist may see the professional, sensitive and accurate interviewing of patients as the basic building block of care which will enable recovery, the consultant may view this as less important than the right dose of the right anti-psychotic, but they are still engaged on the same task. The patient, crucially, does not belong to this group.

#### Patient Beliefs

The beliefs of the patient group can be viewed as separate and distinct from the views of the medical professionals. In addition, one must always be mindful of whether a patient is there by consent (an informal voluntary admission) or by compulsion (a formal admission under the Mental Health Act) as this might give some indication to not just their state of mind, but it may well have some bearing on their attitude and relationships with the various members of the multi-disciplinary team. Like the strands of the earlier churches the patients and doctors hold a different set of beliefs and use a very different vocabulary leading to the same goal, which is recovery. Before entering the mental healthcare system the patient would have had little or no knowledge of its belief systems, and the general agreed beliefs that make each particular multi-disciplinary team work. The teams have to decide whether to convert the patient to their way of thinking (the most common outcome)

or to fight the patient while the patient maintains their own beliefs in tact.

### **Delusional Thinking**

When a patient has delusional thinking these problems are compounded. The patient's complex and fluid beliefs of everyday life have been put under great stress by the disordered thinking he or she is now experiencing. The task of bringing that patient round to a new set of medical beliefs in order to communicate the details of a care-plan, prescription, diagnosis, if there is one, and plans for discharge, is immense and it is not surprising that in receiving communication of large amounts of alien material the deluded patient is lost and confused. This is worsened still further when those delusions are religious in nature.

#### **Poorer Outcomes**

There have been studies which show that patients with religious delusions do less well and have a higher likelihood of relapse. Doering et al came up with the conclusion that, '*surprisingly, a strong religious faith was connected with a worse outcome.*' (Doering et al, 1998, p.95) That is to say that they were more likely to have a relapse of their psychotic symptoms. Doering highlights the difficulty of validly assessing a religious faith and 'the difficulty of differentiating between true religious beliefs and symptoms of the disease, since quite frequently religious delusions constitute a part of the ideational context of schizophrenia patients.' He gives this as the most likely explanation for the poor relapse rate but it opens a glaring omission on the part of the researchers that they made no effort to distinguish between generally accepted religious views, which could be loosely gathered under the umbrella of orthodoxy, and views which are not acceptable or recognised as religious beliefs, which could be categorised as delusions.

Ronald Siddle and his colleagues looked at 193 patients in the Greater Manchester area. They tested Sims' criteria for religious delusions and applied them to their sample. They discovered that those with religious delusions had higher doses of medication, greater fixity of belief and longer prodromal symptoms. They were less well at admission. (Siddle, 2002) In a further study Siddle and his team undertook research exploring the response to treatment in an in-patient ward, between those

with religious delusions and others, and found no difference in their response. However they found that '*In patients with religious delusions, the baseline and post psychiatric treatment scores indicate that these patients are more ill, than a comparable group of patients who have other types of delusion.*' (Siddle, et al., 2002, p.222)

#### **Why do these patients do less well?**

So why is it that patients with religious delusions do less well? Is it really because they are more unwell or is it because of the content of their delusional belief system? How can a psychiatric nurse cross the divide in beliefs to walk beside the religiously deluded? It has been a cornerstone of working with the mentally ill that staff never collude with a delusion, but how do staff express sympathy and understanding in the area of religious delusions unless they have a basic grounding in the theories and beliefs of religious faith? Are the researchers, and the medical staff on wards are walking into uncharted territory when they begin to work within the area of religious belief because they do not have the knowledge to begin to differentiate belief - to separate religious sanity from madness?

Some work has been done on just these sorts of distinctions. Emanuelle Peters writes of a continuum of belief from 'orthodox' Christian faith to the New Religious Movements (such as Hare Krishna or Druids) through to schizo-typal delusional thinking. Peters argues that there are no clear cut divisions between normality and delusional thinking but rather a spectrum of belief. (Peters 2001) There are measurable attributes to the effects of these beliefs in terms of conviction, preoccupation and distress. Also it is true to say that simply because it is hard to draw a line in the sand between normal and delusional thinking it does not mean that delusions cannot still be recognised clinically. (*vide* Sims, 1995)

If the patient believes that they have a spiritual problem, not a mental one do the professionals need to dissuade them of that fact or is it possible to provide professional caring without losing the patient's cooperation in the road to recovery? If the professionals accept the interconnected nature of spiritual and mental health, they need to be skilled in bringing the unwell person to health in a way that respects their spiritual needs as well as their mental health needs.

## Emotional Intelligence

### Recovery Model

One solution might be to adopt the principles of the recovery model. (Repper and Perkins, 2003). This model holds that one should accept the patient's beliefs and work from the ground on which the patient currently stands. This inevitably involves losing the ground on which the professional currently stands, in order to join the patient where they are. This is not an easy experience for the professional as the belief system of the team is their area of comfort and confers upon them their status. It only works when a whole team agrees to take this approach, and even then cannot ever be said to achieve unity of thought, only sufficient companionship to put a patient at their ease.

### Knowing the Other

In my own working life and practice I have come to the conclusion that in order to work with a patient's religious delusions I have to lose my professional identity as one of *them* the sceptical team, and become one of *us*, the patient belief group. I also have to prove my worth to the patient, allowing them to give me their view and not to contradict it immediately, to listen and ask questions that constantly reminded the patient that it is OK, indeed normal, to have a religious faith. Once that fact has been established the discussion of particular delusional beliefs which are not generally accepted to be part of that faith can begin.

### Being Understood

Here, the use of orthodoxy comes again to the fore as the patient is able to understand a religious and spiritual identity for themselves which is not delusional, and can also accept that in losing their mental health problem, the patient would not lose their faith. Thus the model of conversion must be dropped for patients of this kind, any attempt to say, 'No, you have a mental health problem, not a spiritual problem' risks inviting hostility and if the conversion is complete the patient will in fact be defeated, not won round, and the solution will not be lasting. It must be remembered too that in terms of fixity of belief, religious beliefs are often held very strongly and with great fixity, however much religious delusional thinking is fluid and may well ebb as the medication and talking therapies begin to work, it is at this moment that the greatest fear may

be displayed by the patient that everything they ever held dear is being stripped from them. The religious patient feels more vulnerable when they are not understood, or when they feel a hostility towards religious belief, whether expressed or not expressed, by staff or other patients.

### Knowing Oneself

There is a study, though the data is from 1993 and perhaps would merit re-visiting, that demonstrated the religious attitudes of psychiatrists in relation to their clinical practice. In this research 27% reported a religious affiliation and 23% a belief in God (an interesting discrepancy in itself) but 92% reported that psychiatrists should concern themselves with the religious concerns of their patients. 58% of the psychiatrists had never made a referral to a religious leader and the views of the whole sample relating to the connexion between religious faith and mental health were not consistent. (Neelman and King, 1993, p420,421) Therefore there was a discrepancy between their belief in the importance of religious faith to mental health and their practice, actually doing anything about the patient's religious concerns. Perhaps this is partly because there is no clarity about what it is that should be done, or to whom the referral is to be made.

## Conclusion

### Chaplaincy Has a Role to Play

Confusion amongst mental health professionals is not aided by the very different approaches and beliefs of the faith groups. It would not be possible for the mental health professionals to hold an overall view of all the different faith perspectives found in multicultural British society. Yet perhaps better use of chaplaincy services as a conduit for the religious and spiritual needs of patients might provide mental healthcare professionals with a clarity lacking until now, and also provide the patients with a sympathetic practitioner in relation to their spiritual needs who also has good knowledge of the mental health field. Chaplains are the obvious group to give the vital link between the beliefs of the patient group and the requirements of the professionals. There is an obvious opening here for some research to be done in whether there is any efficacy in spiritual care as a method of moderating religious delusion.

After all when faced with the issues of spiritual health there is no option but to retain the humility which accepts that no-one has all the answers for another and a medical model of care does not necessarily negate a spiritual understanding of illness, it is merely a new set of metaphors to describe a different basis of belief. Therefore, as a chaplain I can be orthodox in both camps and I think that more professionals could learn both languages without any detriment to the level of professional care. For the patient with spiritual delusions holding out the hope of their finding their own spiritual health is a very rewarding and fulfilling task. It is to give hope where there is none and to provide, with autonomy and responsibility, a language for recovery.

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