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# PSYCHIATRY AND RELIGION: CURRENT DEBATES AND THEIR CHALLENGE TO PSYCHIATRY

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Professor Gerrit Glas explained that he is a consultant psychiatrist and Professor of Philosophy at the University Medical Centre, Utrecht. He is involved in many groups at the interfaces of philosophy, theology and mental health. The paper was a concentrated summary of a lot of knowledge profitably given to detailed exposition. This would require knowledge of the references, which are therefore provided in full. (The text was read; the full text of the talk is available from christopher@findlay.u-net.com).

Gerrit began with a comment on the apparent strangeness of psychiatry's renewed interest in religion precisely at a time when it had reached a measure of scientific status. After presenting a brief history of the socio-cultural and philosophical developments of which psychiatry is a part, he highlighted possible areas of concern for religion and psychiatry and showed how this related to the present concerns of patients with reference to a typology of anxiety. His conclusions for the future of psychiatry were challenging.

## How did psychiatry and religion become separated.

For ages it was self evident that persons with mental disorder not only needed physical treatment but also raised religious concerns. Although spirituality and healing were closely related in the original personage of the priest, psychiatry and religion diverged deeply from the early nineteenth century onwards. It was part of a wider cultural development described by sociologists like Max Weber as 'modernisation'. This was characterised by increasing specialisation, the separation of means and goals, the separation of facts and values and the subjective from the objective. This leads to the popularisation of a so-called scientific world-view. Psychiatry developed its own language of description and classification and, later, a model of disease similar to the somatic disease model. Modernisation was dependent on scientific and technical advances, which led to a division in the different parts of the production process and to an 'engineering model' of medical practice.

With specialisation came professionalisation and secularisation. Instrumental actions were seen as value-neutral; only goals were value-laden. Medical activities became disconnected from more global notions of their purpose and meaning. Medical practice was reduced to the mere application of scientific insights and findings. The hard core of medicine, in this view, consists of objective facts, and the effective, efficient and morally neutral use of technical procedures. These facts are produced by the application of experimental methods and are therefore regarded as abstract and value-free by nature. The *experience* of illness, on the other hand, and the values that are involved in medical practice, should all be relegated to the realm of subjective experience and personal meaning construction. Religion was also relegated to the sphere of subjectivity, so that religion and psychiatry were

separated. Psychiatry was associated with the objective, morally neutral application of scientific knowledge and religion was transferred to the realm of mere subjective appreciation and strictly personal choice.

**So why the renewed interest of psychiatrists in religion?**

1. This could be seen as an extension of the process of specialisation and professionalisation. Religion may be seen as a special interest, like cross-cultural or women's issues.

2. A response to the influx of people from the third world and Balkan countries, which hold more strongly to their religious convictions than those brought up in the West.

3. Could there be an underlying tension or uneasiness about what could be considered as 'the heart of our profession'? Psychiatrists may themselves believe that their current practice is too limited. It could be more than the application of cognitive instruments. Perhaps psychiatry's aim is not primarily cognitive, but social, moral and even existential.

Societal urges and constraints are continually at the table of psychiatry and cannot be avoided. The rise of anti-psychiatry, patient movements in the seventies and eighties, alternative healing practices and dropouts from conventional treatment may mean that psychiatrists' exclusion of the moral is not working. In everyday practice, psychiatric and existential aspects are almost always interwoven. Existential aspects affect the way symptoms are experienced and expressed. A too narrow conception of psychopathology excludes this existential layer. Conceptual elimination of existential and/or spiritual aspects, may ultimately lead psychiatrists to lose their patients because the patients do not feel understood. Reducing suffering to disease is not an adequate response for patients.

**Some areas of concern**

**1. Education** – ourselves learning and teaching our trainees to address the existential and spiritual needs of our patients, including:

*Knowledge:*

- basic knowledge of major belief systems
- knowledge about the developmental, experiential, and mental health consequences of religious experiences

*Skills*

- improvement of interviewing skills
- improvement of diagnostic skills with respect to people having all kinds of religious backgrounds
- therapeutic skills

*Attitudes*

- systematic reflection on the professional's own belief system (atheism included) and the influence of it on his or her functioning
- analysis of transference and counter-transference issues
- empathy

(There already has been a lot of work on courses in psychiatry and religion in the United States, particularly by David Larson and Francis Lu. The National

Institute of Healthcare Research awarded 14 residency programs with the John Templeton Foundation Spirituality and Medicine award in 1998 and 1999.)

## 2. Epidemiology

- in which way and to what extent is the incidence and course of psychiatric disorder in the population influenced by one's religious background?
- Are there modifying variables (salience; stability of religious convictions)?

Research in the Netherlands illustrates this. Braam conducted a large epidemiological study in which elderly people were investigated with respect to the incidence and course of depression. The course of depression is positively affected by salience of religious belief in a number of associated conditions - chronic disease, pain and functional impairment. Neeleman conducted a large cross-sectional epidemiological study and found that religious affiliation offered a relative protection to the occurrence of psychiatric morbidity. Interestingly, there also seems to be an effect of age. Religiously affiliated men and women both showed less morbidity. However, the effect seems strongest in men, whereas the effect in the women group disappeared with age. It is difficult to explain this finding. One could think, here, of course of factors associated with growing older. Neeleman has suggested that the protective value of religious affiliation diminishes with the increase in age at conversion. The later people are converted, the more unstable they are, which would contribute to a diminishing effect of religious affiliation.

## 3. Psychopathology

- instances of religious psychopathology (e.g., dissociative states)
- issues in the differential diagnosis between religion and psychiatric disorder; (the grey zones between saintliness, asceticism and anorexia nervosa; or between delusion and religious conviction; or between religious belief and magical thinking in obsessive-compulsive disorder; or between religiously inspired habits and behaviours, and personality disorder)
- the multi-layered nature of psychopathology: underneath or behind the layer of symptoms and complaints there are often relational problems and/or psychodynamic conflicts; these, in their turn, not infrequently have spiritual roots, or, at least, have a spiritual dimension
- how does religion protect against or dispose to psychiatric disorder? Pargament's extensive research on religion and coping should be mentioned here. The concept of salience

## 4. Clinical and treatment issues

- How does religion affect the way the patient interprets his problems and apprehends what is said in the consulting room?
- But, the other way around too; how does psychopathology affect the way the patient apprehends his religion?
- In what way can religion be 'used' in psychotherapy and psychosocial treatment?

## 5. Special issues

- psychodynamics of religious groups (cults, sects; Marc Gallanter)
- the psychology of the charismatic leadership
- faith healing rituals
- religion and trauma
- religion and substance abuse

**What the patient needs – recognition of the interwoven-ness of symptoms and existential issues.**

Gerrit suggested that psychiatry currently excludes too much that is central in everyday practice. In illustration of this he presented some of his own work on anxiety (Glas 1991, 1996, 2001). Central to this are three closely connected ideas:

1. that religious or existential issues are central in the lives of at least some of our patients – in any case many more than clinicians are inclined to think;
2. that the way in which these religious issues and their dynamics are expressed is intricately interwoven with the process of symptom formation;
3. that the religious dimension is not some ephemeral intuition but a structural dimension of human existence, which may affect all layers of human functioning, also in psychopathology.

In other words: underneath or behind the layer of symptoms there are not only relational and psychodynamic conflicts – a fact which is commonly acknowledged – but also manifestations of a disturbance in a still deeper dimension of ultimate concern, which is central to the person and his or her life project.

The psychopathology of anxiety offers an excellent illustration of what is meant here. Careful listening to the patient reveals that apart from the objective and subjective symptoms of anxiety there is another dimension of anxiety, highlighting the fact that anxiety may also be seen as an embodiment or immediate expression of the way the person relates to him/herself. This dimension of anxiety is not primarily a fear of a particular situation, future abandonment, for instance. It refers to a basic level of relatedness to oneself and to the world, i.e., a state of fundamental disconnectedness, of which the other anxiety symptoms are an expression. Anxiety, then, is not (only) based on the anticipation of a future state of being rejected. It is not primarily a warning signal. At the level we are speaking of here, anxiety is the immediate expression of a pervasive sense of unconnectedness that affects all relations, the I-self relationship included.

The table provides an overview of the basic anxieties classified according to an underlying theme and its reference to a particular structural dimension. These are:

- ***Anxiety related to loss of structure (chaos)*** referring to the incapacity to maintain a relationship to oneself and/or the world. Things that once looked familiar now change into strange, unfamiliar, and threatening objects.
- ***Anxiety related to existence as such***, representing a horror of the brute fact of one's existence, or a disgust of the world. (Sometimes this horror, or disgust, is directed to one's body, for instance, in cases of anorexia nervosa.) The theme of these anxieties is the facticity of life (its matter-of-

factness). Life does not offer any promise. Everything seems to be neutral. One's inner experience feels frozen.

- ***Anxieties related to the theme of lack of safety***. The person experiences the world as insecure and inhospitable. One may think, here, of the intense terror and desperation after physical or technological disaster.
- ***Anxiety that centres around the theme of unconnectedness or isolation*** is perhaps the pre-eminent fundamental anxiety. What prevails is a tormenting feeling of distance, the awareness of an unbridgeable gap, whether others are present or not.
- ***Anxiety related to the theme of doubt and incapacity to make choices***. This anxiety becomes apparent when a person is not able to cope with the irrevocability of decisions that must be made. The person tries to avoid to make choices. Accordingly, this anxiety represents an inability to commit oneself when this is required.
- ***Anxiety related to meaninglessness (or absurdity)*** is well known from existentialist and post-modern prose. It derives from the lack of (a) a feeling of mastery of one's existence; and (b) the experience of meaningfulness (dedication, vitality). Both sides are closely connected. This anxiety refers to what Kierkegaard calls the possibility of being forgotten or lost in the universe (Kierkegaard 1837, Vol. I, 100; cited via Kierkegaard 1844/1980, 171).
- ***Death anxiety***. The concept of death anxiety again does not primarily refer to the *fact* of one's (own) death or to the *process* of dying. On the contrary, it refers to anxiety as an expression of the openness toward one's finitude and mortality. It consists of honestly and authentically facing the possibility of one's own death. Anxiety, conceived in this way, is closely connected with life itself.

**TYPOLOGY OF BASIC ANXIETIES, THEIR THEMES AND UNDERLYING STRUCTURE**

| *Type* | *Theme* | *Structure* |
|---|---|---|
| **Anxiety related to loss of structure** | **Chaos** | **I - self relationship** |
| **Anxiety related to existence as such** | **Facticity** | **Capacity to shape one's existence** |
| **Anxiety related to lack of safety** | **Vulnerability** | **Physical protection** |
| **Anxiety related to unconnectedness** | **Isolation** | **Affective connectedness** |
| **Anxiety related to doubt and incapacity to choose** | **Irrevocability** | **Historicity; capacity to will** |
| **Anxiety related to meaninglessness** | **Absurdity** | **Mastery; capacity to entrust** |
| **Anxiety related to death** | **Non-existence** | **Openness; capacity to transcend** |

## Conclusions

1. The subject of psychiatry and religion is not merely an area of special interest, it also demands for a re-thinking of the foundations and boundaries of the psychiatric profession.
2. Further development of the field is demanded, especially in the area of education and improvement of clinical skills; however, there is also an urgent need for further research, empirical as well as conceptual.
3. Patients need psychiatrists who recognize that psychopathology in its strict sense is interwoven with spiritual and religious issues.
4. This asks for a new and richer nosology, in which justice is done to structural conditions of which spiritual and religious functioning is one of the expressions.

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