Psychiatry and Religion

Context, Consensus and Controversies

Edited by Dinesh Bhugra

Psychiatry and Religion

In *Psychiatry and Religion: Context, Consensus and Controversies* fifteen senior mental health practitioners and pastoral workers come together to explore what their different philosophies have to offer for the benefit of individuals in their care. An artificial division between spiritual and psychological welfare has led to a parting of the ways between religion and psychiatry and this book attempts to narrow the divide, claiming that there is much room for understanding the same phenomena from different perspectives.

With the aim of promoting greater understanding, the book examines the relationship from three angles. The first places it in its historical context, uncovering the reasons behind the division. In the second part contributors examine the significance of particular belief systems for mental health management. A variety of denominational perspectives are covered, ranging from established traditions such as Christianity, Judaism, Hinduism, Buddhism and Islam to newer, developing religions. The concluding part examines specific issues, looking particularly at the perceived positive and negative effects that strict moral codes and religious rituals can produce.

Psychiatry and Religion: Context, Consensus and Controversies offers mental health practitioners and pastoral workers new ways of approaching the needs of mentally ill people in their care. It challenges misconceptions and paves the way for greater mutual trust and understanding from which the patient will gain.

Dinesh Bhugra is Senior Lecturer in Psychiatry at the Institute of Psychiatry in London.

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FOR
MY MOTHER

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Preface

Dinesh Bhugra

Religion has often been seen as a strong defence against several types of neuroses. The relationship between religion and mental health can be a mutually beneficial one as religion provides guidelines which may help individuals to devise a course for their lives. Violation of religious rituals, excessive sexual activity, etc., may contribute to obsessions, anxiety and depression. Similarities between obsessive behaviour patterns and religious practices have been noted. Religion, however, creates guilt by setting high moral standards but also provides a number of techniques that may help alleviate guilt, e.g. confessions, prayers, chanting, etc. Religion is not a coherent entity that affects all individuals in the same way and neither does mental illness and an interaction between the two is quite an exciting one.

Organised religions may offer some external support as lessons from the religion are introjected in the form of moral, spiritual and real 'eliefs that are important for personality development. Some people may need an abstract image, whereas others rely on a material image to help in worship. Once spiritual levels are attained, individual religions become less important, similar to Maslow's hierarchy (Maslow, 1970). For example, suicide is said to be less common in those who actively involve themselves in and practise religion with genuine conviction, e.g. Catholics. Thus, certain psychiatric conditions affect one's beliefs and certain religious attitudes can predispose to certain types of psychiatric conditions.

The interface between mental health and religion, though an important one, is a neglected area. Authors have offered background reading in different religions, which is obviously not comprehensive but only signposts on a vast journey.

The idea of this book emerged during a meeting on psychiatry and religion held at the Institute of Psychiatry in 1991, and since then, a further biennial meeting has been held and more are planned. The chapters here develop the themes of the two conferences and are not their proceedings, and it is vital that the reader sees the purpose as sharing of information, thoughts, and philosophies. It is hoped that the reader will treat this book as a starting point

only and will be encouraged to look further and deeper. The second half of the book contains contributions on new religions, sects, and the difficulties of dealing with mental health issues like guilt. This volume is an attempt to represent the beginning of the dialogue between two neighbours who should be on very good terms indeed, but, due to a long-forgotten episode over the niggle about the size of a fence, have fallen out. It is high time that commonalities are ascertained and shared and differences are put to one side.

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Part I

Introduction and history

Chapter 1

Religion and mental health

Dinesh Bhugra

Man's faith in religion is as old as humankind itself. The need for a greater force that could be seen as immortal developed as man struggled to survive physiologically and then psychologically and started to make sense of traumatic and not so traumatic experiences. As a result, all illness in the beginning was seen as a responsibility of priests and shamans. They would not only provide descriptions and enable the individual to make sense of this experience but also help the individual and his family to manage the illness in different ways. Priests and physicians were often the same individuals in different civilisations across the world. Physicians did not appear to have any confusion about their dual functioning.

In different medical systems, whether Graeco-Roman or Hindu, psychiatric illnesses were often seen to be due to different types of possession. Management involved dietary restrictions, the use of herbs and prayers (see Bhugra, 1992, for a discussion of Hindu systems). In classical Greece and Rome, with the development of more secular states, a split appeared to have occurred between the profession of priest and physician (Ball, 1985). However, the overlap did continue for a time and physicians continued to work in temples within a single religious framework. Furthermore, a change developed with limited use of religious factors, and outstanding, secular physicians emerged.

The fall of the Roman Empire and the growth of the Catholic Church led to the dual role of priest–physician, with the church becoming a repository for all knowledge. The Galenic principles held a monopoly on medical ideas for a considerable length of time, which meant that the development of medicine as a separate individual system was sluggish. Ball (1985) argues that the chaotic political situation and problems of the Church also contributed to this sense of a lack of innovation or exploration.

The secularisation of medicine has been linked with the parallel development of other professions. Ideas of contagion and possession continued to plague aetiological discourses of psychiatric illness. Ball (1985) blames the resurgence of possession of phobic attitudes towards women along with sexual anxieties and morbid hostility. The persecution of witches was a kind of mass psychosis where charity and compassion vanished and social class, intelligence and

education counted for nothing. Until the fifteenth century, medicine and the priesthood could work together but several reasons, chiefly secularisation, led to the two professions going their separate ways. The development of pathology and the discovery of bacterium led to the 'scientification' of medicine and left psychiatry in the realm of philosophy. The growth of psychiatric asylums and the isolation of the mentally ill from society were a sign of the quarantine where a possibly 'contagious' individual was shunted away and a new class of 'carers/warders' emerged. This has led some authors, notably Szasz, to argue that psychiatrists emerged as the new priests, dealing with confessions and giving absolutions. Taking the imagery further, one could argue that the development of pills added to the communion scenario where the patient is asked to put the pills on their tongue and a small tumbler with perhaps about 20 mls of water is used as 'communion wine'.

Increasingly, mental health practitioners are assuming the three functions traditionally recognised as being in the domain of religion. First, an explanation of the unknown. Second, ritual and social function, and, third, the definition of values (Nelson and Fuller Torrey, 1973). When priests interpreted earthquakes, epidemics and droughts, they were focusing on the explanations of the unknown, and this explanation was responsible for reassuring the masses that things were under control. With the advent of scientific inventions and theories, these mysteries of nature have largely been explained. Whereas formerly, the mentally ill were seen by the priests as possessed by spirits, demons and devils, their odd behaviour was subsequently explained away by psychiatry as 'illness of the mind'.

The competition between the priest and the psychiatrist for the mind and the soul of the individual continued. Psychiatrists were the father figures who gave sage advice and occasionally controlled the patient without appearing to do so. The strength of psychiatry is not as unlimited as that of religions, or rituals. As Crenshaw (1963) comments, there are enough similarities between medicine and religion partly because both serve moral and humanitarian purposes. Science without religion can be destructive, and religion without science can become superstition according to Feibleman (1963). He then goes on to argue that, since the problems of today do not draw a sharp demarcation between what is medical and social or religious, the treatment should cover cooperation of all these disciplines. Although the training, expertise and views of physicians and priests may be different, their sensitivity to various factors affecting the individual in psychic or spiritual pain brings them together on the same level. Neither of the two is, nor should be, morally or scientifically superior. Cooperation between doctor and clergyman is essential in ministering to the total needs of the person (Sholin, 1962). There is, of course, an ongoing debate to ascertain whether mental health is a state leading towards the goal of religious growth, or whether religion is only one part of a mentally healthy person whose goal may be biological or social adaptation (see Sutherland, 1964). The *raison d'être* of the psychiatrist is to alleviate suffering of the mentally ill and support, treat and manage such an individual along with managing members of the

family and the community that such an individual affects. The Church and the priest, on the other hand, also have to provide a therapeutic environment, intercede for the sick, administer the sacrament, help man prepare for death, and in general inculcate the somewhat personal faith that upholds one in difficult times (Feilding, 1964). Thus, it would appear that, as the psychiatrist prepares the individual with an array of coping strategies, the priest can do exactly the same. The process of psychic immunisation can thus be approached in two ways, which do not have to be in competition with each other for the individual's soul.

The interaction between religion and psychiatry can be at several levels. Psychiatric patients may have religious beliefs that may need to be taken into consideration when planning any management. They may also seek help from religion and religious healers, using different models of distress. The interaction of the therapist's religious views and the patient's religious views may cause conflict. The patient's religious values may affect acceptance of psychotherapy and other treatments. Furthermore, symptoms of one kind may be understood completely differently by someone else. Possession states are a classic example of this. In a recently completed study, Campion and Bhugra (1994) found that 75 per cent of their psychiatric patients had consulted religious healers about possession and similar findings have been reported from other parts of India. On the other hand, while looking at possession syndromes, Teja *et al.* (1970) and Varma *et al.* (1970) reported that these conditions were seen in women, and were largely hysterical in origin. Spirit possession remains a 'culturally sanctioned, heavily institutionalized and symbolically invested means of expression in action for various egodystonic impulses and thoughts' (Kiev, 1961). Life events have been linked to the onset of these states. Their management has to include clear understanding of the cultural background and the explanations of the experience.

Morris (1987) argues that, with the growth of materialistic interpretations of social reality, the general interest in comparative religions emerged. The phenomenological approach of religion made its appearance. Phenomenology is (its) instrument of hearing, recollection, restoration, and of meaning, as are the underlying meanings of religion. Jung (1938) went so far as to suggest that religion is not only a sociological or historical phenomenon but that it also has a profound psychological significance. He defines religion as a numinous experience that seizes and controls the human subject (Morris, 1987). The Jungian approach too is phenomenological. Although Jung (1938) argues that the phenomena are true thoughts–these can be understood by relating these to 'collective unconscious'–a psychic reality shared by all humans.

Religion, its psychological aspects, and its practice all affect mental health. Beliefs about mental illness and its treatment may be closely tied to beliefs about sin and suffering and views that mental illnesses may result from some kind of separation from the divine, or even possession, by evil (Loewenthal, 1995). Psychiatry may be mistrusted and religious healers may use modified versions of cognitive–behavioural approaches.

Loewenthal (1995) suggests that good mental health may go with religiously encouraged social support, religious ideas, feelings, experiences and orientation. The continuing collaboration and consensus between religion and psychiatry are essential for the well-being of patients, but it is also important to be aware of the conflict between two disciplines.

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Chapter 2

Religion and psychiatry

Extending the limits of tolerance

K. W. M. Fulford

INTRODUCTION

Religion and psychiatry occupy the same country, a landscape of meaning, significance, guilt, belief, values, visions, suffering and healing. This indeed is the world of the psyche, itself interchangeably soul or mind (Bettelheim, 1982). Yet the relationship between the two disciplines, which in the past has ranged from mutual suspicion to open hostility (Lipsedge, this volume), is even in today's more liberal times hardly more than one of tolerant indifference. Pastoral counselling has brought the two sides closer (Sutherland, this volume), but the 'religiosity gap', in Lukoff *et al.*'s (1992) apt phrase, remains: psychiatric history taking, as John Cox (this volume) notes, although covering many of the most intimate details of a patient's life, normally does not include enquiries about religious beliefs, notwithstanding the fact that these are likely to be important for up to three-quarters of patients. Conversely, while priests may nowadays be willing to engage the help of psychiatrists, there is little in the way of formal guidance on where spiritual or psychological interventions are appropriate, with even those closest to psychiatry acknowledging significant tensions (Foskett, this volume).

So far as psychiatry is concerned, there are a number of prejudices standing in the way of a closer relationship with religion. Many of these are dealt with in this book. It is said that religions attract the mentally unstable–but the mental health of the followers even of new religious sects is if anything above rather than below average (Barker, this volume). It is said that religions may have their origins in madness (Littlewood, this volume)–but madness can also be a source of creativity in art and science (Storr, 1972). It is said that religious experience is phenomenologically similar to psychopathology (visions are like hallucinations, for example)–but this is to confuse form and content: normal and pathological varieties of religious experience stand to be differentiated by essentially the same criteria as normal and pathological varieties of non-religious experience (Jackson and Fulford, forthcoming). It is said that paranormal experiences are a product of definable patterns of brain functioning–but as

Fenwick (this volume) points out, paranormal experiences are no less invalidated by their grounding in neuro-physiology than are normal experiences. It is said that religions are harmful, that they induce guilt, for example (Nayani and Bhugra, this volume)–but religion, no more than psychiatry, is not harmful as such. It is also said, conversely, that religious belief is ineffective–but there is empirical evidence that it is not, improved 'coping', for instance, being correlated with religious faith in a variety of adverse situations (Griffith and Bility, this volume; Koenig *et al.*, 1992). The effectiveness of religion in this respect is no proof of its metaphysical claims (a delusion could be just as effective). Also, it is unclear from published work whether it is specifically religious faith which is required (there have been no double blind faith trials). But this work none the less does dispose of the question of efficacy as such.

There are, though, deeper reasons for the separation between psychiatry and religion. These have to do with the identification of psychiatry with what is sometimes called the 'medical' model (Macklin, 1973). According to this model, medicine is, essentially, a science. Psychiatry, therefore, in identifying with the medical model, has come to think of itself as a branch of science, and hence, by common implication, as separate from religion both epistemologically and ethically. Thus as a science, psychiatry is assumed to be based on observation and experiment, and, in principle, open to objective testing. Religion, on the other hand, is taken to be 'revealed', its knowledge claims being rooted in authority and upheld through faith. Again, as Littlewood notes in this volume, the identification of psychiatry with science implies a naturalistic ethic. Psychiatry employs an essentially deterministic model of human thought and behaviour within which actions are morally neutral. Whereas religion, in most Western traditions at least, assumes freedom of action as the basis of moral responsibility. Though, by contrast, the guiding ethic of psychiatry, along with the rest of medicine, is the principle of autonomous individual patient choice, whereas that of religion is subordination of individual choice to the will of God.

The separation between science and religion is perhaps a peculiarly Western phenomenon (Cox, this volume). In the first two sections of this chapter we will find that viewed in either of its aspects, epistemological or ethical, it is considerably less clear cut than it is commonly assumed to be. Contrary, though, to recent attempts at reconciliation, it will be argued here that the separation between science and religion is genuine and, ultimately, irreducible. This is because it reflects an essential ambiguity in our natures as human beings, namely that we occupy simultaneously a world of facts (in which science is mainly operative) and a world of values (in which religion is mainly operative). Recognising the reality of the divide between fact and value does not lead to a widening of the gap between religion and psychiatry, however. On the contrary, it shows that psychiatry, just to the extent that it is concerned with human beings, rather than merely with mental machines, is intrinsically connected with religion as well as with science. Religion and psychiatry should therefore move from tolerant indifference to tolerant engagement as the basis of good practice in both disciplines.

EPISTEMOLOGICAL ASPECTS OF THE DIVIDE

Along with the rest of medicine, psychiatry has developed in the twentieth century largely as a scientific discipline (Zilboorg and Henry, 1941). The work of Karl Jaspers, Emil Kraepelin and others helped to establish a firm basis for descriptive psychopathology and classification, these being further elaborated and formalised in recent decades through such innovations as structured examinations of the mental state (Wing *et al.,* 1974) and operational criteria for the diagnosis of a wide range of mental disorders (American Psychiatric Association, 1980; World Health Organisation, 1992). Building on this careful descriptive work a number of important advances have been made in treatment, through psychopharmacology, through the development of counselling and psychotherapeutic skills, and by applying the principles of behavioural and cognitive science to symptom modification. Moreover, following the classical pattern of the development of a new science (Hempel, 1961), causal brain-based theories of mental disorder–although still somewhat tentative and preliminary–are beginning to emerge from the new technologies of dynamic brain imaging and molecular genetics.

All this appears very different from religion, then. Indeed, the development of psychiatry as a science, with all its attendant successes, is widely perceived as having been made possible in part only by the shedding of religious mysticism and dogma. As Lipsedge notes (this volume), the case has often been overstated. Moreover, religious and psychological explanations of mental distress are not necessarily counterposed: in the Jewish and Hindu traditions, in particular, they are complementary (see, respectively, Cooper and Bhugra, this volume). But modern causal theories of mental illness, as disturbances of mental functioning, are none the less generally regarded as displacing the possession theories on which religious explanations of the phenomena of mental illness have often been based. Science, it could be said, has, literally, cast out the demon, replacing the moral categories of madness with the value-neutral categories of scientific disease theory. Freud went so far as to explain religion away as a form of pathology: it represented a neurotic avoidance of the demands of a mature relationship through the substitution of an ideal father figure for the imperfect biological father (Freud, 1927).

This account of the development of psychiatry is one with which perhaps a majority of psychiatrists would identify. They would recognise, perhaps, the historical contribution of religion to the development of humane treatment of the insane, in the work of Tuke and others at the end of the eighteenth century. They would acknowledge, increasingly, the significance of the ethical and experiential aspects of clinical work in psychiatry. But at the heart of their subject they would identify an emergent psychiatric science, undogmatic, transparent, testable; replacing acts of faith with empirical investigations, ineffable mystery with understanding, revelation with the cautious development of objective theory through prediction, test and falsification.

Closer inspection of this picture shows, however, that it is at best

over-simplified. This is partly because, as we will see later, there is more to psychiatry than just science. More fundamentally though, the point is that even as a science, psychiatry is not like this at all. This is essentially because, on all three points–freedom from presupposition, transparency and objectivity–science itself is not like this either.

Thus in the first place, there is a clear sense in which science, no less than religion, depends on certain presuppositions, certain 'acts of faith'. It must be assumed, for the scientific endeavour to get going at all, that induction 'works'–for there can be no scientific (i.e., inductive) test of this (Russell, 1912). It must be assumed, similarly, that there is no limit to the explanatory power of science, no question which science cannot answer. For this can be shown only by default, in the sense that the question itself cannot (in principle, cannot) be susceptible to scientific test. Moreover, the core virtue of science, the supposed objectivity of its observations, depends on a tacit fiction. For an observation requires an observer; an observer, as the philosopher Thomas Nagel (1986) has put it, has a 'point of view'; and the fiction of science is to suppose that its account of the world is somehow from no point of view at all, that in Nagel's phrase, it is a 'view from nowhere'.

Fiction or not, though, it may be said, science does work, it makes the world more transparent, less mysterious, for science explains things that before were inexplicable. But the effect of this, at least in the paradigm science of physics, has been to reveal a deeper level of mystery beneath the mysteries of the everyday world. What is involved here is not the plain difficulty of modern physics, the impenetrable mathematics of some of its formulations, and the difficulty of translating these mathematical concepts into visualisable images (12-dimensional spaces!); still less is it the popular extrapolations of these concepts into metaphors of 'holism', 'connectedness', 'indeterminacy', and so forth. The mystery revealed by physics is rather in the world view to which we are led by physics itself, on its own territory, and by way of its own mathematics.

This is nowhere more dramatically illustrated than in quantum mechanics. As a mathematical tool kit, for predicting the behaviour of matter and energy on the smallest scales, this is widely regarded as the most successful physical theory ever devised. Yet the world view to which it points is one in which reality is (within limits) determined by the observations which we choose to make. Again, we need to be careful to see just how mysterious this is. It is not merely that observations at the atomic level disturb the world to an extent of which we can never be exactly sure. There is indeed uncertainty in this sense built into quantum mechanics. But more than this, a quantum mechanical measurement (in part) actually determines what is there. Observer and observed are thus woven together in quantum mechanics in a way which is wholly contrary to the spirit, not to say the letter, of a classical understanding of science. The classical, indeed the common sense, way of understanding a measurement is that it extracts information from a pre-existing and in principle independent system. But a quantum mechanical measurement (in part) determines the state

of the system. And this is no longer a matter merely of speculation. The two ways of understanding measurement–'extracting information' and 'determining the state of'–may under certain circumstances produce measurably different results (d'Espagnat, 1976). This was used by Einstein as the basis of a thought experiment designed to show that quantum mechanics is incomplete. But when the experiment was done, it showed, on the contrary, that quantum mechanics was right and Einstein was wrong (Aspect, 1986)!

The world as revealed by science is thus no less mysterious than the world as revealed by religion. This, moreover, has been most clearly recognised by those who have contributed most to the development of modern physical theory (Bell, 1986; Einstein, 1960; Feynman, 1965). We can add, then, that the world as revealed by science is mysterious, not to the extent that we lack deliberative understanding, but, on the contrary, in direct proportion to the extent of our deliberative capacity.

The natural response of the scientific hard-liner to all this is to fall back on the third supposed characteristic of science, its objectivity. The world view derived from science may be mysterious, so this line of argument might go, it may indeed require certain presuppositions, but it differs from that of religion in being based on objective data, on the facts, rather than on divine revelation. Yet even this is not as straightforward as it seems. For as Quine first put it, scientific theories are always underdetermined by the data (Quine, 1948). Any set of data can be explained by more than one theory. And when we look at what more is required to establish a given theory, we find ourselves involved, at best, in aesthetics, with concepts like simplicity, elegance and economy, and at worst in the personal and political value structures within which science as a human endeavour necessarily proceeds.

The post-empiricists have made much of this (see e.g., Kuhn, 1962; Lakatos, 1970). It is not merely, they claim, that the practice of science requires a certain ethic (though of course it does–not 'rigging the data', for instance). It is rather that the very theories we adopt, and hence the world view to which science leads, are a product of the values of the scientific community. All world views, then, scientific and non-scientific, are, according to post-empiricism, on a par, valid within the community in which they arise, but none more nor less true to 'reality'. This may seem far-fetched. But even in physics, at the leading edge of hard science, we find hints of the value-embeddedness of knowledge to which post-empiricism has pointed. In writing of the measurement problem in quantum mechanics, for instance, the physicist and philosopher Bernard d'Espagnat concludes that Bohr's interpretation of quantum mechanics (which is the standard interpretation) 'ultimately defines instruments with reference to *our desires*' (d'Espagnat, 1976, p. 95, emphasis in the original).

All this is not to suggest that science is, somehow, unsound. Clearly, by the (biblical) measure of its fruits, it is not. Nor is it to suggest that science is no different from religion. We will see later that, on the contrary, there is an essential gap between them. The point is rather that if we are to come to an understanding of the relationship between psychiatry and religion, we must first see that science