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Working with patients with religious beliefs[1]

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Abstract Mental health professionals in Western societies are generally less religious than their patients and receive little training in religious issues. Using case studies, the author discusses issues involved in working with patients who hold religious beliefs: problems of engagement; countertransference; religious and spiritual issues not attributable to mental disorder; problems of differential diagnosis; religious delusions; religion and psychotherapy; psychosexual problems; and religiously oriented treatments. The article ends with a discussion of the various ways in which religious themes can be incorporated into mental health work, especially the need to involve religious professionals and develop collaborative patterns of working together with mental health professionals.

Mental health professionals are likely to encounter patients with religious beliefs or patients who have religious issues, as part of their everyday clinical practice. Traditionally, psychiatrists and psychologists have underemphasised religious issues in their work (Larson, 1986; Lukoff & Turner, 1992; Sims, 1994; Crossley, 1995). Religion is often seen by mental health professionals in Western societies as irrational, outdated and dependency-forming, a view deriving from Freud (1907: p. 25) who saw it as a 'universal obsessional neurosis' (Box 1). For similar reasons the topic of religion plays little part in psychiatric training, which may be selected by people of a lower level of religiosity than the background population (Shafranske & Malony, 1990; Larson & Larson, 1991; Rubenstein, 1994). It is no wonder that the Danish theologian Hans Kung referred to religion as 'psychiatry's last taboo' (Kung, 1986).

Several studies highlight a 'religiosity gap': psychiatrists are often far less religious than their patients (Kroll & Sheehan, 1981; Neeleman & Lewis, 1994). Both the general public and psychiatric patients report themselves to be more religious and to attend church more regularly than mental health professionals (American Psychiatric Association Task Force, 1975). In fact, a Gallup poll in 1985 indicated that a third of the general population in the USA considered religion to be the most important dimension of their lives, and another third considered it to be very important (Gallup, 1986). Keating & Fretz (1990) report evidence that religious individuals are less satisfied with a non-religious clinician than with a religious one.

1. For an invited commentary on this article see Sims (2004, this issue: pp. 294–295).

There are signs that things may be slowly changing. A number of authors are beginning to underscore the importance of mental health professionals taking into account patients' religious and spiritual lives during the psychiatric consultation (Sims, 1994; Crossley, 1995; King & Dein, 1999). Cox argues that:

> 'if mental health services in a multicultural society are to become more responsive to "user" needs then eliciting this "religious history" with any linked spiritual meanings should be a routine component of a psychiatric assessment, and of preparing a more culturally sensitive "care plan"' (Cox, 1996: p. 158).

Recent attempts at empirical assessments of the relationships between religion, spirituality and mental health suggest that religion may actually promote better mental health (Batson & Ventis, 1993; Koenig, 1998; Pargament & Brant, 1998). However, this work is limited to Christianity and Judaism, and there has been little exploration of this topic in other religious groups. Some patients may define their problems as spiritual rather than religious; by 'spiritual' they generally mean a transcendent relationship between the person and the 'higher being' – 'a quality that goes beyond a specific religious affiliation' (Peterson & Nelson, 1987). The term

Box 1 Antagonism towards religion

Many psychiatrists see religion as:
- primitive
- guilt-inducing
- a form of dependency
- irrational
- having no empirical base

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'religion' refers to 'adherence to and beliefs and practices of an organised church or religious institution' (Shafranske & Maloney, 1990). This distinction has been deployed by some contemporary researchers in the field of religion and health (e.g. King *et al*, 1999).

This article is not an overview of the relation between religion and mental health; rather it focuses on the specific issues involved in working with patients with religious beliefs: problems of engagement, countertransference, religious and spiritual issues not attributable to mental disorder, problems of differential diagnosis, religious delusions, religion and psychotherapy and religiously oriented treatments. It largely focuses on Judaeo-Christianity on account of my own professional experience, although the same principles apply to working with other religious groups. A major ethical issue when working with patients with religious beliefs is the degree to which psychiatrists should be involved in discussing religious issues. For instance, should a secular psychiatrist become involved in discussing the religious issues of a devout Catholic patient, if they impinge on that patient's mental health?

Problems of engagement

A rejecting attitude towards psychiatry is common to many religious groups. There are many reasons for this. First, the stigma of mental illness may affect the marriage prospects of members of religious communities.

Case 1

Sarah, a 50-year-old devout Jew, wrote to her psychiatrist. She had suffered from low mood for some years and had been diagnosed with chronic depression. She took paroxetine regularly but remained anxious much of the time. In her letter, she asked her psychiatrist to provide confirmation that her condition was not hereditary, since she was seeking an arranged marriage for her 18-year-old daughter. She feared that her daughter's marriage prospects would be significantly reduced if anyone knew of her mental illness.

Second, in many religious groups psychiatry and psychology are considered suspect (Greenberg & Witztum, 2001) – both dismiss dogma and God's existence. To turn to a doctor may express a lack of faith in God's ability to help (Peteet, 1981).

Third, patients may perceive doctors as at best failing to understand their religious beliefs and at worst ridiculing them; consequently, they may have little faith in medical professionals.

The psychiatrist may overcome this resistance in a number of ways. It may be necessary to use a 'culture broker', someone from the same religious group as the patient who acts as the patient's advocate. Another important technique is to make use of the symbols of the religion which are important to the patient. For instance, some ultra-orthodox Jews (particularly Hasidim, who have little contact with the secular world) may be unaware of current affairs, but can answer questions on familiar topics such as the religious festivals and Bible readings.

Countertransference issues

Mental health professionals may become angered by patients with religious convictions, arguing that they hold 'primitive' and repressive beliefs that may be detrimental to mental health. They may ask themselves how religious patients adhere to their belief systems in the absence of 'empirical' evidence. Greenberg & Witztum (1991) suggest that therapists may react to such emotions in a number of ways:

- with excessive curiousity about the patient, asking many questions about the patients' religious beliefs and practices;
- by ignoring cultural influences or tensions and treating the patient as though her or she belongs to the same cultural group as themselves;
- by behaving aggressively towards the patient, becoming angry when the patient refuses to comply with treatment or accept the psychiatrist's formulation.

Case 2

A liaison psychiatrist was asked to see a 60-year-old woman with a fungating breast carcinoma. Despite 'much persuasion' she had refused to accept any surgical intervention. The surgeon who referred her felt that she was 'quite irrational' in stating that God would save her life. He felt angry that she refused what he considered life-saving treatment.

This woman was a devout Christian Scientist who had always trusted in God to cure her. Christian Science eschews modern medicine, placing faith in God's ability to heal. There was no evidence that she was depressed or psychotic. The psychiatrist who assessed her felt that she was quite competent to make this decision.

How should religious or spiritual problems be assessed?

How should psychiatrists classify religious or spiritual problems? A new diagnostic category of religious or spiritual problem (V62.89) has been included in the DSM-IV (American Psychiatric Association, 1994), as part of ' Other conditions that may be a focus of clinical attention', in order to offset the tendency of mental health professionals to ignore or pathologise religious or spiritual problems. This acknowledgement marks a significant breakthrough (Turner *et al*, 1995).

Common religious problems that may be a focus of clinical attention include questioning and loss of faith, change of religious denomination, conversion to a new religion and intensification of adherence to the beliefs and practices of one's own faith. Loss or questioning of faith is a common religious problem which may be particularly difficult for patients at an early stage of religious development. These problems should be distinguished from functional psychiatric disorders, although they may lead to psychiatric illness. Their resolution generally requires referral to religious professionals.

One particular form of 'religious' conversion is that occurring when a person joins a new religious movement or cult regarded by the public as being oppressive. Although there is little evidence that belonging to such a religious movement is generally detrimental to mental health (Richardson, 1985; Barker, 1996), it appears that leaving one – often by forcible removal – may result in a number of problems, including agitation, panic attacks, nightmares and repetitive chanting, a phenomenon called 'information disease'. Rarely, religious movements may have extremely detrimental effects on their adherents, even to the extent of pushing them to suicide, as did the Branch Davidians in the USA (Dein & Littlewood, 2000). Bogart (1992) reported on the psychological problems that may arise when a member of a spiritual group separates from his or her spiritual teacher; these include agitation, low mood and nightmares.

Although psychiatrists in the UK may rarely be asked to see members of new religious movements, they need to be aware of the Information Network Focus on Religious Movements (INFORM), a voluntary organisation that provides information about such movements and that can recommend access to counselling services (http://www.inform@lse.ac.uk).

Mystical states

Mystical experiences are common in the UK and the USA, with about a third of people reporting them at some stage of their lives (Hay, 1987). These experiences include feelings of unity with the universe and ecstatic states associated with universal love. Although the feelings are transient, they may lead to permanent changes in cognition and lifestyle and may have an integrative function. It is likely that these states are a normal part of brain function. They may occur spontaneously, be induced by drugs or occur during meditation. Not in themselves symptoms of psychiatric disorder, they can occur in pathological states such as temporal lobe epilepsy and in psychosis, when they are usually associated with an elevation of mood. It is important that psychiatrists respect and differentiate unusual but integrating experiences from those that are distressing or disorganising (Gabbard *et al*, 1982). A negative response to a mystical experience may intensify an individual's sense of isolation and block his or her efforts to seek assistance in integrating and assimilating the experience. There has been much discussion of the difference between mystical and psychotic states (Clarke, 2001). Generally, there are few problems in differentiating the two phenomena using criteria such as the negative effect on life functioning, loss of volition and loss of insight, which occur in psychosis but not in mystical states (Box 2).

Box 2 Differentiating psychotic states from religious experiences

In psychosis:

- experiences are often very personal
- their details exceed conventional expressions of belief
- in many cases, the only distinguishing feature is the intensity of the belief, with the patient thinking of nothing else
- onset of the beliefs and behaviours marks a change in the patient's life, with a deterioration of social skills and personal hygiene
- episodes often involve special messages from religious figures

Another psychological phenomenon which has been vigorously discussed in the academic literature in the past few years is the near-death experience – when a person while clinically dead (i.e. without a heartbeat) has the sensation of leaving their body and, characteristically, floating into a tunnel towards a perceived mystical source. It is not attributable to a mental disorder (Basford, 1990; Fenwick & Fenwick, 1995), although anger, depression and isolation may occur following this experience. Generally, however, individuals report beneficial after-effects, including positive attitude and value changes and some personality transformation. However, at times the near-death experience can be associated with negative psychological sequelae.

Case 3

A 50-year-old woman was referred to a psychiatric out-patient clinic following an episode of septicaemia during which she spent 2 weeks in intensive care. Her heart had stopped on two occasions. She described a number of experiences during this time, one of which was a journey to the 'abode of the dead', where she saw corpses lying in coffins who suddenly became animated and spoke to her. At the time she believed herself to be dead. Following recovery, she was preoccupied with these experiences and had difficulty making sense of them; she also developed a morbid fear of death. The psychiatric interview revealed marked anxiety in relation to dying. Diagnostically, it

appeared that she had been in a delirious state secondary to hypoxia and septicaemia; this delirium was the likely cause of her near-death experience.

Religious delusions

At times it may be difficult to distinguish religious beliefs from frank delusions. In psychotic disorders there is frequently an overlap between the mental disorder and religious and spiritual problems – especially in manic episodes, which often contain mystical components (Podvoll, 1987). Similarly, Goodwin & Jamison (1990) have noted the prominence of religious and spiritual concerns in people with bipolar disorder. Religious delusions may be defined as delusions that have a religious content that is not socially acceptable or shared by other religious people. Sims (1992) outlines the criteria for characterising a belief as a religious delusion:

- Both the observed behaviour and the subjective experience conform with psychiatric symptoms. The patient's self description of the experience is recognisable as having the form of a delusion.
- There are other recognisable symptoms of mental illness in other areas of the individual's life, such as delusions, hallucinations, mood or thought disorder.
- The lifestyle, behaviour and direction of the personal goals of the individual after the event or after the religious experience are consistent with the natural history of mental disorder rather than with a personality-enriching experience.

Religious delusions generally are of three types: persecutory (often including the Devil), grandiose (involving messianic beliefs) and belittlement (including beliefs about having committed unforgiveable sins). The prevalence of religious delusions varies between studies. In a UK study of patients with schizophrenia, Littlewood & Lipsedge (1981) quoted figures of up to 45% in the Black immigrants in their sample compared with 14% in the White UK-born patients. Siddle (2000) found a prevalence of 24% in a sample of patients admitted to hospital with a diagnosis of schizophrenia. Religious delusions are found in a number of psychiatric conditions, including depressive and bipolar disorders, schizophrenia and delusional or organic disorders (as the case study below demonstrates).

Case 4

A 55-year-old African man was admitted to hospital under Section 3 of the Mental Health Act 1983 following severe neglect and odd, disinhibited behaviour. He had previously been given a diagnosis of schizophrenia but had not taken any medication for over 2 years. While on the ward he repeatedly expressed the belief that he was 'God of the universe' and claimed to have supernatural power to heal. He demonstrated no sign of hypomania but a striking degree of apathy and self-neglect. There was no cognitive impairment. Serological tests for syphilis during routine investigation were significantly positive, and a diagnosis of tertiary syphilis was confirmed by lumbar puncture. His delusions responded to a depot medication and intramuscular penicillin. However, his apathy continued to be a problem.

There is some evidence that religious delusions may result in harm to self and others (Field & Waldfogel, 1995). Individuals may act on passages from the Bible telling them to pluck out offending eyes or cut off limbs, and a study of psychiatric inmates in an American penal institution (Scarnati *et al*, 1991) found that over half of its most dangerous inmates had religious delusions.

Case studies 5 and 6 point to the difficulty of differentiating religious beliefs from delusions. The borderline between these entities may be unclear, and members of the person's religious community are best able to differentiate between normal beliefs and religious delusions.

Case 5

A 22-year-old woman had become a 'born again' Christian at the age of 15 after attending a service at which a well-known preacher gave a sermon. Although always describing herself as religious, her church attendance fluctuated according to her mood. She suffered from periods of low mood associated with anorexia, and during these episodes she felt hopeless and had marked suicidal ideation. She regularly cut herself as a source of purification. Even when well she expressed the belief that the world was sinful because of the continuing influence of the Devil. Much of her conversation centred on a continuing conflict between the 'powers of good and the powers of evil'. During one episode of severe depression she spoke of the Devil causing her harm and of a constant fight inside her. She took this belief to be literal.

The question arose as to whether or not she was psychotic. Was her belief in the Devil a normative belief, an overvalued idea or a delusion?

Case 6

A 25-year-old Nigerian woman had arrived in the UK 6 months prior to her compulsory admission to a psychiatric unit. Following her arrival in Britain she had joined a Pentecostalist church. Over several months her level of religiosity had increased. For 2 weeks prior to admission she had taken to preaching in the street that 'Jesus is our Lord' and 'You will only be saved if you come to Jesus'. For nearly a week she did not sleep and hardly ate. On the day of admission she was involved in a fracas with a passer-by and was taken to hospital under Section 136 of the Mental Health Act.

During her assessment in the accident and emergency department she appeared dishevelled, was overactive, overtalkative and preoccupied with telling

the doctor how important it was for him to come to Jesus. When it was possible to interrupt her she admitted to being 'a sister of Christ'. There was no evidence of any other abnormal ideation. She did not believe that she was ill, and held that she was on a mission. She was given 100 mg of chlorpromazine and soon fell asleep.

The following morning she was much calmer and settled. She admitted that her behaviour had been 'over the top', a sentiment shared by members of her church who visited her. By the evening, however, she recommenced talking about 'coming to Christ', upsetting a number of fellow patients. At midnight she went to bed. At 2 a.m. the nurse checked on her to find that she had forced open the window in her room on the third floor and jumped to her death (adapted from Dein, 2000).

What was this woman's diagnosis? Was she hypomanic? Manifesting a brief psychosis? Was she in fact psychotic at all?

Spirit possession

There is some – albeit little – recognition of spirit possession in Western society. Bishop Dominic Walker (the co-chairman of the Christian Deliverance Study Group) points out that although schizophrenia would seem to be the obvious explanation for those complaining of hearing voices or thought insertion, there are cases in which the symptoms disappear 'after the appropriate ministry' (Walker, 1997: p. 3).

Case 7

A 26-year-old White British man who was not religious was referred to the psychiatric out-patient department with the following history. Two months prior to referral he and a group of friends had been playing with a Ouija board. The following night he started to believe that a spirit had entered him through his rectum and was controlling his behaviour: for instance, the spirit made him move and speak in a certain way.

He sought help from a local church, where he was told it was a psychiatric problem and that he was not really possessed. Although he insisted that he had never believed in spirits in the past, now he was deeply upset by this spirit and just wanted it to go. When interviewed he was visibly distressed but appeared to have no other psychopathological feature. There were no first-rank symptoms. Two exorcisms at a local church by a Church of England minister failed to achieve any improvement. A provisional diagnosis of schizophrenia was made (on account of passivity) and he was prescribed regular neuroleptic medication, which caused stiffness. He failed to return to the out-patient clinic, was not deemed sectionable and was not seen again in the clinic.

It is debatable whether this man did in fact have schizophrenia or whether he was a highly suggestible person with a possible dissociative state.

Religious behaviour or obsessional illness?

The relation between religiosity and obsessional illness has been discussed by a number of authors. A review by Lewis (1998) suggested that religiosity is associated with obsessional traits but not with obsessional neurosis. Similarly, Greenberg & Witztum (2001) pointed out that a review of the prevalence of obsessive–compulsive disorder in a variety of cultural backgrounds does not implicate religious background as a causative factor in this disorder. Here the emphasis is on differentiating religious behaviours from obsessional illness, which can be difficult (Box 3; Greenberg & Witztum, 1991). Liaison with religious authorities may be necessary in the treatment of religious obsessive–compulsive disorder, since a religious figure may be able to discourage patients from the performance of religious behaviour.

Case 8

A 26-year-old man, who belonged to a group of ultra-Orthodox Jews, presented with a number of problems. Since joining the movement 5 years earlier he had made few friends. Members of the community had remarked that he spent several hours a day in synagogue reciting the daily prayers (far in excess of the time required). During this he would become extremely aroused and at times would shout out the prayers. He prayed at the expense of performing other religious activities such as studying and at the expense of his own personal hygiene. He told other members of the group that it was essential that the prayers were recited perfectly or else they had to be repeated.

I was asked to see him because members of the community felt that he was ill. When I met him he was dishevelled and smelly, with very poor social skills. He was extremely reluctant to talk to me and muttered a few words, one of which sounded like an expletive. I was unable to interview him formally in any depth. Clearly his religious behaviour exceeded what was expected. My impression was that he suffered from a severe obsessional illness. He refused treatment.

Box 3 Differences between obsessive–compulsive and religious behaviours

In obsessive–compulsive disorder:

- compulsive behaviours go beyond the 'letter of the law'
- the person is interested only in a specific religious ritual, not in the practice of the religion generally
- the person neglects other aspects of the religion that are not the focus of the obsession
- The ritual typically exemplifies obsessional themes, e.g. cleanliness and checking

Religious ideas in psychotherapy

Patients with religious beliefs may bring up religious ideas and images in therapy. Jungian psychoanalysts emphasise the importance of religion in patients' lives, especially in those over 35 years of age:

> 'there has not been one whose problem in the last resort was not that of finding a religious outlook on life' (Jung, 1933: p. 229).

Freudian and object-relations theories of religion focus on the influence of early relationships on the image of God and the quality of the relationship between the individual and God. For instance, Rizzuto, a psychotherapist in the object-relations tradition, suggests that the image of God is formed from elements originating in early object relations (Rizzuto, 1992). Spero (1992) demonstrates how religious concepts can change over the course of psychotherapy. Common themes that arise in psychotherapy with patients with religious beliefs concern God being punitive, or the perception of having let God down.

Case 9

A 70-year-old man was referred to psychiatric services with a moderate depressive illness associated with marked suicidal ideation. He was being seen as an out-patient and treated with fluoxetine. His history reflected several religious themes. He had been adopted at the age of 3 years; his adoptive mother emotionally and physically abused him, and he was very afraid of her. She punished him almost at whim, and expected his behaviour to be exemplary at all times. At the age of 18 he became a monk, which upset his mother. After spending 5 years in a monastery he decided the life was not for him and married a woman much older than him, who had three children of her own. She died after 12 years of marriage.

Much of his discussion in out-patient therapy centred around how much he had let God down. His image of God was of a 'harsh dictator' who did not tolerate any indiscretion and was keen to punish anyone who failed to keep religious observances to the letter. It soon became obvious that his image of God reflected his relationship with his overpowering and punitive mother. During his therapy sessions we looked at his guilt concerning the way he had treated his mother and his extreme anger towards her. Over time his image of God changed to a more benevolent one, as he slowly felt less guilty.

Psychosexual therapies

To date there is no work specifically examining the epidemiology of psychosexual problems in specific religious groups. Religious groups may prohibit certain forms of sexual behaviour. For example, masturbation is strongly forbidden by the major world religions. For this reason, patients with religious beliefs may not be able to engage in some psychosexual therapies such as the Masters & Johnson 'sensate focus' treatment, which deploys masturbation. Psychosexual techniques may have to be modified for these groups. On account of the prohibition relating to premarital sexual relations and gender segregation in certain religious communities, some couples may lack knowledge of normal sexual functioning, and an essential part of psychosexual counselling for these groups involves the provision of basic information about this.

Collaboration between psychiatric and religious professionals

At times it may be necessary to enlist the help of a religious professional such as a chaplain or someone influential in a religious organisation. Hospital chaplains in the UK receive some training in mental health through the College of Health Care Chaplains. They may provide help with religious problems such as discussion of the relation between sin and mental illness, provision of absolution and prayer for patients. They can provide guidelines relating to the 'normality' of religious beliefs. An issue that is frequently raised is the 'why me?' question. How can a good God allow a person to suffer? One common answer emphasises that God is with the person in their suffering, consequently engendering hope. As Koenig *et al* point out:

> 'Armed with faith, hope, spiritual knowledge, spiritual understanding, spiritual power and perhaps most important, humility, the religious professional is often the most qualified and sometimes the only person who can meet the underlying spiritual and religious needs that give rise to the patient's questions' (Koenig *et al*, 2001: p. 450).

Chaplains are increasingly becoming a part of the multidisciplinary team in the UK, a fact justified on the basis that religious and spiritual needs are prevalent among patients with acute and chronic mental illness. They can be involved at all stages of the patient's illness, from diagnosis to discharge planning, and should be available to provide religious or spiritual support or counselling, including helping patients to discover a new spiritual vision for their lives. Religious professionals may be the first 'port of call' for those with mental health problems, and there is a need for collaboration between religious and mental health professionals, especially when dealing with those with serious mental illness. To this extent, religious professionals need to be taught to recognise common psychiatric problems. Likewise, mental health

professionals require teaching about problems of a more spiritual nature.

Conclusions

There is a need for future research to examine the prevalence, clinical presentations and relation to major mental disorders of religious and spiritual problems. In psychiatric practice mental health professionals need to be more aware of issues of religion and spirituality, and require education about the major teachings of diverse religious groups (Meyer, 1988). There is a need for more collaboration with religious personnel. Incorporation of religious themes into psychotherapy with religious patients may lead to enhanced efficacy. For example, using religious imagery in cognitive–behavioural therapy with patients with religious beliefs may be more effective than therapy lacking in this imagery (Propst *et al*, 1992). Other therapists have argued for the incorporation of religious values such as confession (Harrison, 1988) and forgiveness (Hope, 1987) into psychotherapy. The value of so doing remains to be demonstrated.

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Multiple choice questions

1 Religious delusions may occur in:
a schizophrenia
b depression
c anxiety states
d anorexia nervosa
e organic states.

2 In terms of religious beliefs and practices:
a psychiatrists are generally more religious than their patients
b religious teaching plays little part in psychiatric training
c there is some evidence that religious patients prefer religious therapists
d a significantly greater number of mental health professionals undergo religious conversion compared with the general population
e hospital chaplains in the UK have no training in mental health problems.

3 Mystical states:
a are usually pathological
b can lead to changes of personality
c may occur in epilepsy
d require medication
e are more common in men than women.

4 In terms of psychotherapy:
a Freud held a negative view of religion
b Jung held a positive view of religion
c perceptions of God derive from early childhood relationships
d perceptions of God never change during psychotherapy
e the addition of religious components to cognitive therapy may enhance efficacy for religious patients.

5 Religious patients' reluctance to engage in psychiatric treatment may be overcome by:
a using a culture broker
b using religious symbols
c neuroleptic administration
d brief cognitive therapy
e using the Mental Health Act.

MCQ answers

1	2	3	4	5
a T	a F	a F	a T	a T
b T	b T	b T	b T	b T
c F	c T	c T	c T	c F
d F	d F	d F	d F	d F
e T	e T	e F	e T	e F

Epidemiological medicine's best-kept secret?

INVITED COMMENTARY ON... WORKING WITH PATIENTS WITH RELIGIOUS BELIEFS

Andrew Sims

Even to have a paper on working with patients with religious beliefs in a psychiatric journal is a liberating experience, and Dr Dein (2004, this issue) has dealt with his subject with thoroughness and fair-mindedness. We have come a long way since the standard British textbook of psychiatry in the 1960s (Mayer-Gross *et al*, 1960) could state that religion is for 'the hesitant, the guilt-ridden, the excessively timid, those lacking clear convictions with which to face life'. At that time religious belief

in patients was equated with neurosis, and in trainees in psychiatry it was regarded as being seriously unscientific and was strongly discouraged.

Although this topic comes over to us in Western Europe as refreshing and novel, in many countries this would be the everyday experience of clinical psychiatrists, who would be likely to respond 'Of course we work with patients with religious beliefs; all patients have religious beliefs'. In fact, most of our patients too have religious and/or spiritual beliefs, but they are not in the habit of talking about them, especially to psychiatrists, who they suspect might attempt to discredit them.

One of the best-kept secrets of modern epidemiological medicine is the effect that religious belief and practice have upon outcome from both physical and mental disorders. Twelve hundred outcome studies and 400 critical reviews have formed the subject matter of the *Handbook of Religion and Health* by Koenig *et al* (2001). On all of the 13 factors for improved mental health, religious belief proved beneficial in more than 80% of studies, despite very few of these studies having been initially designed to examine the effect of religious involvement on health. If the overall effects of our patients' religious beliefs are so beneficial, then we, as psychiatrists, have no business to undermine or ignore them.

It is important to make a distinction psychiatrically between those who hold, with absolute conviction, extreme beliefs, as have been described by Galanter (1989), and the vast majority of patients who hold, with varying degrees of doubt and questioning, more conventional and culturally accepted beliefs. This does make a difference for the attitudes and practice of the psychiatrist. It is therefore important that psychiatrists respect and differentiate unusual but integrating experiences from those that are distressing or disorganising.

In this connection Dein's idea of a 'culture broker' is attractive. In fact, it is relevant to more than just religious discrepancies between psychiatrist and patient. The culture broker accepts and respects the knowledge and skills of the professional and realises that they can be helpful for the patient. The broker should be a person of good standing in their community, who can advocate this treatment, and this treater, to the patient, while helping the professional to present psychiatric knowledge in a culturally acceptable manner.

Treating psychiatrically disordered people with religious beliefs is a true test of the psychiatrist's capacity for empathy. As well as having a good knowledge of psychiatry, the psychiatrist needs to know about the nature of the religious beliefs and their relevance for the patient's individual condition – to understand so exactly the interplay between belief and subjective experience by inquiry of the patient that, when the psychiatrist gives an account back to the patient describing the patient's own experience and conflict, the patient recognises this with ownership.

Since 2000 the Royal College of Psychiatrists has had a Spirituality and Psychiatry Special Interest Group (http://www.rcpsych.ac.uk/spirit). This was established following greater recognition by psychiatrists of the spiritual and religious needs of their patients, and also because psychiatrists wanted to explore the relationship between their own beliefs and practice and their professional work. With regard to the treatment of patients, the Special Interest Group presents us with a further opportunity to develop Dr Dein's excellent lead. However, it must be remembered that there is for psychiatry the same danger that the highly successful hospice movement met for terminal care just because of its success. Sometimes, it was found that general hospitals did not improve the quality of their terminal care but just referred all patients on to a hospice. Psychiatrists who are not members of the Special Interest Group should not consider that referral of a 'spiritual' issue to the Group absolves them, personally, of all further concern or involvement and that religious patients have to be referred to a 'specialist' who is a member of the Group.

Dr Dein has made an excellent start. As he writes, there is a need for more work in this area. I hope that *APT* will follow his lead and regularly carry articles on working with patients with religious beliefs in different contexts and specialties within psychiatry.

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