# Christianity and Psychiatry

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# Foreword

John Peteet along with his colleagues Steven Moffic, Ahmed Hankir, and Harold Koenig in *Christianity and Psychiatry* have produced a unique and important addition to a rapidly increasing literature. What renders the volume unique? First, they provide a critical yet often overlooked perspective on the topic. Let me suggest what I believe to be that perspective and its context. The authors, whether Christian or from other religious traditions, educate us about Christian influenced approaches to assisting the mentally ill. Many Christians (as do many Muslims and Jews) profess a religious affiliation yet practice their professional therapies and investigations based primarily on our current mainstream knowledge of psychiatric disorders and their treatment. A mainstream view is not anti-Christian or anti-religious. Rather, among these therapists (for the most part) their faith tradition and clinical practice are conceptually and practically separated. We no longer witness the bitter duels between, for example, atheistic Freudian analysts and Christian counselors [1]. Such an uncoupling by Christians who are mental health practitioners in most cases is simply a desire to accommodate multiple views and, frankly, not to "worry" about the philosophical and ethical, not to mention practical, questions that mainstream mental health professional theory and practice pose to Christians.

Herein lies the important distinction in this book. The authors, from varied standpoints, address the central issue of Christian practitioners being *informed* by their faith in their practices. Their faith consciously influences their practice each day and they view their professional roles as a Christian vocation or calling. The book includes a clear personal statement from John Peteet illustrating just the point.

Second, the process of a Christian informed therapeutic practice is worked out from multiple points of view beginning with a history of the "fraught" relationship between psychiatry and Christianity. Perspectives from Jewish and Muslim therapists about their own practices and their interactions with Christian therapists are a central part of this book and widen the perspective even further. These chapters continue the dialogue across these three groups that was begun in the previous books in this series, *Islamophobia and Psychiatry* [2] and then *Anti-Semitism and Psychiatry* [3], so that all practitioners understand the basic doctrines, practices, challenges, and history of the major religions in the USA. Spirituality is not generic

but derives from millennia old texts and traditions. I was especially enlightened by the discussions of topics closely tied to a faith based practice. These include the empirical study of religion/spirituality and mental health outcomes, educating Christians about mental health, Christian integrated psychotherapy, sacred moral injury, and the key role of Christian therapists in treating and caring for the disabled, to name just a few topics.

Finally, this work appears at a most opportune moment in the history of the treatment of mental health in the developed world. For the first time in the past 100 years, affiliation with any religious group has dipped below 50% in the USA and the declines are even greater in Europe [4]. Our society has become increasingly secular in the sense that the basic tenants of the Christian faith are being abandoned. Grounding the practice of Christian mental health professionals firmly in their faith tradition in my view becomes a most important witness to mental health professionals overall. Corresponding and perhaps correlated to this trend is the quite dramatic increase in mental illness and its consequences. According to the U.S. Center for Disease Control, a survey in June of 2020 found that 31% of respondents reported symptoms of anxiety or depression, 13% reported having started or increased substance use, 26% reported stress-related symptoms, and 11% reported having serious thoughts of suicide in the past 30 days. These numbers are nearly double the rates we would have expected before the pandemic [5]. Undoubtedly the pandemic has been the major contributor, yet mental illness was becoming more prevalent in the USA prior to the pandemic, despite advances in our understanding of the brain. Care of the mentally ill must again become the central driving force in the fields of psychiatry and psychology. And that care can only be enhanced by faith based practitioners, well trained and knowledgeable, who take on this care as their vocation and commit themselves to the study and practice of their respective professions.

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# Introduction

Eighty four percent of the world's population is religiously affiliated, and 68% of the 16% of unaffiliated individuals in the USA believe in a higher power [1]. Research has shown significant effects of religion/spirituality (R/S) on mental health, largely positive but also some negative, and interest continues to grow in the bidirectional and complex relationship between faith and mental health. Yet many clinicians feel unprepared to address what can be pervasive implications of the patient's R/S on their treatment, or to enlist the resources of their faith tradition in their care.

The nuanced relationship between Christianity, one of the world's five major religious traditions, and psychiatry can be important for mental health clinicians to understand when treating believers, working in cultural contexts shaped by their religious beliefs, or attempting to integrate their own faith into their work with patients. Chapter authors in this book first consider challenges posed by historical antagonisms, church-based mental health stigma, and controversy over phenomena such as hearing voices. Next, others explore both how Christians often experience conditions such as mood and psychotic disorders, disorders in children and adolescents, moral injury and PTSD, and ways that their faith can serve as a resource in their healing. Twelve Step spirituality, originally informed by Christianity, is the subject of a chapter, as are issues raised for Christians by disability, death, and dying. A set of chapters then focuses on the state of integration of Christian beliefs and practices into psychotherapy, treatment delivery, educational programming, clergy/clinician collaboration, and treatment by a non-Christian psychiatrist. Finally, there are chapters by a mental health professional who has been a patient, a Jewish psychiatrist, a Muslim psychiatrist knowledgeable about Christianity and psychiatry in the Muslim majority world, and a Christian psychiatrist. These chapters provide context, diversity, and personal perspectives.

Three of the editors have recently co-edited Springer volumes titled *Islamophobia and Psychiatry* and *Anti-Semitism and Psychiatry*, books which have uniquely benefitted from bringing together the perspectives of their different faith traditions. The participation of Dr. Koenig adds the expertise of the foremost psychiatric researcher in the field of medicine, including psychiatry, and religion. We believe that mental

health professionals will find practical help in this volume to not only understand but also to address the particular challenges that arise when caring for Christian patients. Religious patients and family members will also discover ways to integrate their faith into their understanding of mental disorders and treatments. Church communities, pastoral care providers, and mental health professionals will encounter models for effectively collaborating. Finally, the growing number of clinicians interested in promoting flourishing of the whole person will find many examples in this volume of how religious values and experience can benefit both providers and those for whom they care.

The Editors

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# Chapter 1
# The Fraught History of Psychiatry and Christianity

**Samuel B. Thielman**

## Introduction

In his well-known book the *History of the Conflict Between Religion and Science (1896)*, American physician John Draper (1811–1882) observed that:

> Of all the triumphs won by science for humanity, few have been farther-reaching in good effects than the modern treatment of the insane....On one side have stood ... various philosophies, the dogmatism of various theologies, the literal interpretation of various sacred books... all compacted into a creed that insanity is mainly or largely demoniacal possession; on the other side has stood science, gradually accumulating proofs that insanity is always the result of physical disease. [1], p 97

Recent historical scholarship has convincingly refuted the "science vs religion" narrative [2] as it pertains to the histories of science and medicine. In fact, as this chapter will show, the story of the relationship of psychiatry and Christianity is not one of chronic mutual antagonism, despite the impression given by older accounts of the development psychiatry such as those related by Henry Maudsley [3] or Krafft-Ebing [4], pp 37–46. Rather, Christians who have concerned themselves with the care of those who were mad have frequently incorporated the insights of medicine into the treatment of patients. In the modern period, though, with the emergence of "Naturalism" as an ideology pitted against Christianity [5], there has indeed been antagonism between psychiatry and Christianity.

The use of the term "psychiatrie" as a word describing the medical study of mental disorders is usually attributed to the German "romantic" psychiatrist Johann Reil (1759–1813), and fittingly so, since Reil and other German psychiatrists of the early nineteenth century advocated an approach to the insane that took into account

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both medical and psychological influences [6]. Yet in a broader sense, psychiatry has its roots in the medical literature of the ancient world. Ancient medical texts, including the Hippocratic writings, discussed disorders of the mind at some length [7]. Since the early days, writers of the church talked about emotionally distressed individuals using contemporary ways of understanding and frequently promoted the humane and sympathetic treatment of such people.

Charles Taylor, in his book *A Secular Age*, has observed that the Western world prior to the Renaissance was "an enchanted world." The influence of invisible spirits lays behind phenomena observed by the senses. This is certainly true where treatment of mental disorders was involved, and yet the Christian church's approach to what we currently understand as "mental illness" took many forms. There were strongly held views that spiritual forces influenced the mind, and many, though not all, knowledgeable Christians also looked to medical knowledge for help in treating the mad.

## The Early Church to the Middle Ages

### *Demonology, the Supernatural, and Early Medical Remedies: Augustine and Chrysostom*

The view of the church toward mental illness or "madness" (the term sometimes used by historians to avoid anachronistic thinking) has its roots in the New Testament. There we are told that Jesus healed people with many diseases. Matthew 4:24 tells us: "his fame spread to all of Syria, and they brought to him all who were sick with various diseases and racked with pain, those who were possessed [*daimonizomenous*, literally, demonized], lunatics [*seleniazomenous*, literally 'moonized' or moonstruck] and paralytics [*paralutikous*], and he cured them" (New American Bible, rev. ed.).

So, in the New Testament understanding of phenomena, there could be different categories for people afflicted with demons and those affected by the moon, such as "the mad" and epileptics.

In Matthew 17:14–18, the same word is used to describe a condition which is either lunacy or epilepsy:

> When they came to the crowd, a man came up to Jesus, falling on his knees before Him and saying, "Lord, have mercy on my son, for he is a *lunatic* and is very ill; for he often falls into the fire and often into the water. I brought him to Your disciples, and they could not cure him." And Jesus answered and said, "You unbelieving and perverted generation, how long shall I be with you? How long shall I put up with you? Bring him here to Me." And Jesus rebuked him, and the demon came out of him, and the boy was cured at once. (NASB)

Interestingly, in the Septuagint, there is a similar issue raised when the Jewish translators of the second century BCE translate the Hebrew word "shaga," meaning "raving mad," into Greek in I Reigns (I Samuel) and in Psalms. In I Samuel 21:15

where David feigns madness before Achish, King of Gath, the word "madness" is translated by the Septuagint into the Greek word *epilepton* meaning "suffering from epilepsy" [8]. So there was a similarity between epilepsy and lunacy in the minds of the translators of the Septuagint, since both conditions seemed related to the sublunar sphere. A more naturalistic view of epilepsy appears in the Hippocratic writing *The Sacred Disease*, so even in the first millennium before the "common era," there was more than one view for the basis of madness [9, 10], pp 3–27.

Historian Gary Ferngren has recently argued that the Christian view, from the beginning, has not simply been a "pan-demonologic interpretation" [11], p43. A view that the early church attributed all to demons and made no room for natural science misconstrues what actually was going on, since physicians are praised in the deuterocanonical writings of the Bible. Sirach 38:1 tells readers, "Honor physicians [*iatron*]; honor a physician for his services for indeed the Lord created him. For healing is from the Most High, and he will receive a gift from a king. .... The Lord created remedies out of the earth, and a prudent man will not ignore them" (from *New English Translation of the Septuagint*). And the Gentile physician Luke (identified as such in Colossians 4:14) is credited by the church with writing the third gospel of the New Testament [11], pp 42–63. The attitude reflected in Sirach is the attitude of the early church. God heals, but God also puts remedies in the earth and gives the physician, who himself is godly, the skill to use his knowledge to provide therapies that by God's grace will heal. As will be shown, several early church fathers also spoke well of the medical approach to mental affliction.

The early Christian religion was a religion, in part, of healing, but modern scholarship has argued that there is little evidence of outright hostility toward medicine or physicians. In fact, the objections by early Christians to medical healing were generally not to the use of medical remedies but to forms of healing that involved magic, witchcraft, necromancy, astrology, or worship of anything other than the one God [12], p 33–42. For example, Tatian (c. 120–c. 180 AD) spoke out against the use of roots and amulets and herbs to accomplish evil ends, through their use as love potions or in curses (p. 72). However, when he spoke of the use of material means to treat insanity, he said "...how is it becoming to ascribe to matter the relief of the insane, and not to God? For by their art they [practitioners of this healing art] turn men aside from the pious acknowledgment of God, leading them to place their confidence in herbs and roots" [13], p 72.

But Tatian's point of view did not predominate in the church of late antiquity. Several prominent early church leaders held views of physicians consistent with Roman culture at large and with the view expressed in the wisdom of Sirach. For example, Augustine of Hippo (354–430 AD) writing in the early fifth century compared Christ to a physician dealing with the madman in his exposition on Psalm 35 (36) verse 11:

> Our humble God came to heal humankind of its grievous wound of pride; he came, for the word was made flesh, and lived among us….When they said to him, you have a demon…He let it go… He was a physician who had come to cure a lunatic. Now a physician does not care what a deranged patient says to him, but bends his efforts to finding out how the patient may get better and be sane once more. [14], p 87

Here is one of the most prominent of all thinkers of the Christian church speaking with admiration and sympathy of the physician who treats the madman, using the doctor-patient relationship as a way of explaining Jesus' attitude toward human beings whose minds are blinded by sin. The underlying implication is that lunacy can have a cause that is properly treated by a physician and that the good physician is a compassionate person valued by the church.

John Chrysostom (c. 347–407), Bishop of Constantinople in the early fifth century, writes with similar regard for the role of the physician in the care of those with mental distress in a very different context. An extensive correspondence between John Chrysostom and the Deaconess Olympias, from the late fourth or early fifth century, contains advice from the bishop to this deaconess about her poor health and ongoing dejection, revealing the attitude of the Eastern church toward physicians. He wrote:

> … Dejection causes sickness; and when the body is exhausted and enfeebled, it remains in a neglected condition, deprived of the assistance of physicians, and of a wholesome climate, and an abundant supply of the necessities of life… I beseech you dear lady, to employ various and skilled physicians, to take medicines which avail to correct these conditions. [15], p 293

He goes on then to describe his use of medicines to cure his own infirmity. The point here is that Chrysostom saw dejection as something that could produce illness (as well as the other way around), and he understood the proper remedy to be physician-directed care (as well as good religious counsel, which he also recommended). The Christian dimension is always present in Chrysostom's letters to Olympias, but not to the exclusion of attention to physical treatments as a means of addressing spiritual or mental distress and dejection. A human being was seen as both physical and spiritual in nature, and physician-directed remedies could help.

The world of late antiquity and the middle ages was, as noted above, a world in which almost everyone, Christian and otherwise, understood there to be a supernatural dimension to the world of disease, including mental disease. The Leechbook of Bald, from c. tenth-century Britain, reflects the medical world of the middle ages:

> For protection "against the elfin race and nocturnal goblin visitors … take the ewe hop plant…wormwood, bishopwort, lupin, ashthroat [and 10 other ingredients]; put these worts into a vessel, set them under the altar, sing over them nine masses, boil them in butter and sheep's grease, add much holy salt, strain through a cloth … if any ill tempting occur to man, or an elf or goblin night visitor come, smear his forehead with this salve, and put it on his eyes, and where his body is sore, and cense him with incense, and sign him frequently with the sign of the cross; his condition will soon be better." [16], p 345

This passage is helpful for several reasons. First, it represents the work of someone who was a physician. The writer believes that the condition he is treating involves the influence of nonhuman spiritual entities, and he uses both symbolic religious activity as well as herbs in his treatment approach. The treatment was for, in part, "any ill tempting" that occurred to a person. It is also an example of the fusion of a local theory of the forces behind psychological distress (elves and goblins), a material/medicinal remedy, combined with (perhaps) a request for God's grace. Another remedy calls for mixing particular plants, then saying three masses,

and then applying the poultice before 9 am and at night, followed by a sung litany, the Apostles' Creed, the Lord's Prayer, and "writ[ing] Christ's mark on each of his limbs," followed by some other procedures [16], p 347. Again, there is a combination of a local theory of mental illness, physical remedies, and invocation of the power of God in Christ. This Christian/medical combined approach to mental distress would continue, in different forms, in the centuries to follow.

## Fifteenth- to Seventeenth-Century Therapeutics

### *New Types of Treatments: "Physick" and Moral Therapy – Baxter, Rush, and Pinel*

By the fifteenth and sixteenth centuries, views on the role of the supernatural in the origins and cure of madness by physicians had changed. This was, in part, related to disillusionment with the power and corruption of the Roman church in areas of Europe. Works appeared from writers containing open discussions of the extent to which madness was an expression of demonic influence. Physicians and others challenged the pan-demonic view of madness.

Among the most interesting of Renaissance books with a multifaceted view of claims of supernatural influence and power is Reginald Scot's (c. 1538–1599) *Discoverie of Witchcraft* (1584). Scott was a surveyor, not a physician, but he gives evidence of serious medical learning in his discussion of melancholy in this book. The title, *Discoverie of Witchcraft*, should be understood as meaning the exposure or explanation of witchcraft. Scott gives many non-supernatural explanations for phenomena normally understood to be evidence of an evil supernatural power. In particular, he discusses the cure of Ade Davie, wife of Simon Davie, a man living in Kent in southeast England. Scott tells us that he actually knew Davie and that he got his account of Ade's illness from Simon Davie himself. As Scott relates it, Ade had become pensive and sad. Her husband, who was a prominent householder in the area, was concerned that his reputation might be affected, such that people would see him as a bad provider husband. He kept Ade's condition secret. However, Ade became more emotionally distressed and stayed up at night with "sighing in secret lamentation." She pretended to her husband that nothing was wrong but eventually confessed to him that she had sold her soul to the devil and that it was "to be delivered to him in a short space."

Simon Davie comforted her, telling his wife to "be of good cheer, this thy bargain is void and of none effect: for thou has sold that which is none of thine to sell; sith it belongeth to Christ who had bought it and dearly paid for it, even with his blood …." She wasn't convinced and confessed further that she'd bewitched him and the children, but Davie replied that Christ would "un-witch" them, since no such evil could happen to those who love God [17], p 32. After relating this story, Scot concluded that even when people confess to witchcraft, it's no evidence of

witchcraft, since in this case Ade Davie "... was brought low and pressed down with the weight of this humor [black bile] so as both her rest and sleep were taken away from her; and her fancies troubled and disquieted with despair...." [17], p 32. And Scot argued that, despite the clearly natural origin of her confessions of being a witch, she was in danger of being condemned by witch hunters – the point of *Discoverie of Witchcraft* being that witchcraft doesn't exist and that (speaking as an English Protestant) "popish charms, conjurations, execrations, and benedictions are not effectual, but be toys and devises only to keep the people blind, and to enrich the clergy" [17], p 280.

Certainly, in the sixteenth century, it was possible to maintain religious belief without attributing cases of melancholy madness to a supernatural cause. Of course, others very much believed witches existed, including witches. That was the world of the day. And certainly, ideas of demonology existed in the sixteenth century among physicians as well as laymen. Andrew Boorde, writing in *The Breuiarie of Health* (1587), wrote, under the heading of "Demoniacus," "This matter [causes] all manner of sicknesses and disease, and it is a fearful and terrible thing, to see a devil or devils should have so much power over a man …," though Boorde, a physician, did not limit the effects of demons to madness [18], Book 2, p 4.

By the seventeenth century, both Protestants and Catholics, clergy and physicians were moving away from such supernatural explanations for madness. There are many illustrations of how both clergy and physicians thought the relationship among spiritual, psychological, and medical factors influenced people suffering from various forms and degrees of madness – and different writers, naturally, gave priority to the domain in which they had the most expertise.

Richard Baxter (1615–1691), in his massive book of directions for Christian living, *The Christian Directory*, offered a view of the English Protestant approach to melancholy in the later seventeenth century. Baxter was a peace-loving, mature, experienced pastor who, though usually identified as Presbyterian, was so peace-loving that even now he's commemorated annually in the Church of England Calendar for the Christian Year (June 14). His approach to melancholy may be considered representative of a significant swath of English-speaking Protestants in the seventeenth century. During this time, the term "melancholy" described a wide range of conditions involving intense sadness. Baxter had little patience for religionists who over-spiritualized depression. He wrote:

> … I see some persons that are unacquainted with the nature of this and other diseases exceedingly abuse the name of God, and bring the profession of Religion into scorn, by imputing all the affects and speeches of … melancholy persons to some great and notable operations of the spirit of God [whom Baxter did not believe was conveying an overt spiritual message to every person who was self-condemning because of melancholy]. [19], p 312.

Speaking of all the negative thoughts and imaginations that a Christian might have who was melancholy, Baxter observed:

> [T]he involuntary effects of sickness [such as melancholy] are no sin: melancholy is a mere disease in the spirits and imagination, though you feel no sickness: And it is as natural for a melancholy person to be hurried and molested with doubts and fears and despairing

> thoughts, and blasphemous temptations, as it is for a man to talk idly in a fever when his understanding faileth…. [19], p 318.

Baxter counseled against solitariness and lengthy isolated prayer and meditation. He concluded "My last advise is, to look out for the cure of your disease and commit yourself to the care of your Physician, and obey him: And do not as most melancholy persons do, that will not believe that Physick will do them good; but that it is only their soul that is afflicted. …I have seen abundance cured by Physick: and till the body be cured, the mind will hardly ever be cured, but the clearest Reasons will all be in vain." We can take it from this that, in the seventeenth-century England, mature clergy like Baxter did not oppose medical remedies for depression, did not believe all mental illness was due to the devil or to spiritual causes, and had a broad view of the remedies that could be properly applied to those suffering from melancholy. But this was certainly not true of all [20].

The eighteenth century saw the development of "moral therapy" for those being treated for mental distress, an approach that emerged in various locations around Europe, but was particularly well developed by Quakers who founded the York Retreat in England in the late eighteenth century in response to the inadequate care for the insane by the local asylum. William Tuke (1732–1822) and his family founded the Retreat in 1792. They employed a physician but wanted their Quaker approach to prevail and were particularly intent on treating the mentally ill as rational and moral beings worthy of esteem. A non-dogmatic Quaker outlook formed the underpinnings of their approach [21], pp 28–29. Samuel Tuke (1784–1857), William's grandson, wrote that "To encourage the influence of religious principles over the mind of the insane, is considered of great consequence, as a means of cure. For this purpose, as well as for others still more important, it is certainly right to promote in the patient, an attention to his accustomed modes of paying homage to his Maker" [22], p 102.

Similarly, two strains of understanding of the influence of religion on mental health appear in the well-known writings of two eighteenth-century writers on mental illness, Benjamin Rush (1746–1813) and Philippe Pinel (1745–1826). Rush, a prominent American physician and teacher in the late eighteenth and early nineteenth centuries, viewed religion (by which he meant Christianity, broadly understood) as a positive influence on mental health, at least in most cases. Rush was a prolific, thoughtful, and clinically active physician from the time of the American Revolution who thought deeply about religion. Known (somewhat anachronistically) as the father of American psychiatry, he was concerned about the moral life of the nation. He was a staunch opponent of slavery, an opponent of the use of alcohol, a proponent of the use of the Bible in education in the public schools, and an opponent of capital punishment. As a young man, he had studied at the College of New Jersey (now Princeton University) and then for 2 years at Edinburgh University, where he received his medical degree. Since Rush was in Edinburgh during the height of the Edinburgh Enlightenment, he not only studied under the surgeon William Hunter and the renowned medical teacher William Cullen (1710–1790) but also met David Hume and, later, in London became acquainted with Benjamin

Franklin and even Samuel Johnson and playwright Oliver Goldsmith [23]. Rush was a signer of the Declaration of Independence, represented Pennsylvania in the Continental Congress, and wrote influential books on medicine in the late eighteenth century.

Rush's book *Medical Inquiries and Observations Upon Diseases of The Mind* is considered to be the first American textbook of psychiatry. Rush was aware of arguments that religious excitement was a cause of insanity. However, he did not believe that religion, properly practiced, led to mental illness. He wrote: "… We sometimes observe intellectual derangement to occur from the moral faculties being unduly excited by visions and revelations … [but] let not religion be blamed for these cases of insanity. The tendency of all its doctrines and precepts is to prevent it [insanity]."

He went on to observe that healing through spiritual means was a much better treatment for a condition of the mind he called "derangement of the moral faculties", writing that "However useful the rational and physical remedies that have been mentioned may be to prevent or cure vice, they never can perform that work completely, without the aid of that supernatural and mysterious remedy which it hath pleased God to unite with them in his moral government of his creatures, and that is, the forgiveness of it. In vain have legislators substituted … [the death penalty and] painful corporeal punishments, for this divine mode of curing moral evil" [24], pp 364–365.

## The Nineteenth to the Early Twentieth Century

### *Religious Enthusiasm, Hypnosis, and the Emergence of Modern Psychiatry*

In the nineteenth century, journals focusing on psychiatry and related topics were established in Europe and the United States [25], p 31. As knowledge about mental illness, its causes, and treatment was discussed and thought about more widely, concerns about the role of religion in mental health could be more broadly discussed. (At this point, I will have to focus on the trajectory of religion and psychiatry in the United States due to space limitations, but there is a similar trajectory in Britain and Europe.)

Of particular concern to many physicians was the impact of "enthusiasm." Amariah Brigham (1798–1849) is the best known American physician of the early nineteenth century to bring attention to the negative effects of "enthusiastic" religious practice. Although psychiatry as a profession had not yet established itself in the United States, Brigham became interested in nervous and mental conditions. He served as a physician at both the Hartford Retreat and the Utica Asylum, where he was the superintendent. At his own expense, Brigham established the *American Journal of Insanity*, which was highly successful and eventually morphed into the *American Journal of Psychiatry* in the early twentieth century. Few at that time

would have seen well-behaved religionists as risking mental health, but many were concerned about the uncontrolled and emotionally intense behavior exhibited in revival meetings, camp meetings, and similar spiritual gatherings. Brigham wrote two books on the relationship of religion and mental health: *Remarks on the Influence of Mental Cultivation and Mental Excitement Upon Health* (1833) and *Observations on the Influence of Religion Upon the Health and Physical Welfare of Mankind* (1835). *Observations* contained Brigham's concerns about negative psychological effects of many Christian practices including monasticism, fasting, and using wine in communion, but he was especially concerned about the emotional effects of camp meetings. After a lengthy discussion on these matters, he did point out that he was not condemning Christianity as a moderately practiced religion, only that the form of it was disturbing to mental health, explaining:

> ... we find that all great excitements have ever caused an increase of insanity, and other affections of the brain.… Our revolution and the excitement of the war increased insanity in this country; and during the first revolution in France [the French Revolution], cases of this disease were frightfully multiplied.… Religious excitement, therefore, like all mental excitement, by affecting the brain, may cause insanity and other diseases. I wish, however, here, to state my belief, that pure religion — Christianity — has no such effect; but the abuse has. The religion of Christ condemns that excitement, terror and fanaticism which leads to such effects; "for God hath not given us the spirit of fear; but of power, and of love, and of a sound mind." 2 Tim 1:7 [26], pp 284–285.

Brigham, we are told by a contemporary biographer, was not at the time particularly religious [27], although he became much more religious toward the time of his death. He increasingly adopted a more moderate tone in expressing his worries about religious excitement and those prone to emotional instability. Although Brigham's book received a chilly reception from some, it expressed the opinions of many of his medical contemporaries [28].

Modern medicine and psychiatry emerged from the organizational structures and the scientific mindset that coalesced in the early nineteenth century. During the second half of the century, asylums for the insane proliferated, and asylum physicians moved away from the optimism that had characterized treatment of the mentally ill in the Retreat-based model. As to the role of religion in the asylum, Wilhelm Griesinger (1817–1868), a prominent German psychiatrist of the second half of the nineteenth century, presented a view of spiritual phenomena that many psychiatrists today espouse:

> …Nothing can be assumed as to the relation existing between these mental acts and the brain, the relation of the soul to [the] material [body]. … How a material physical act in the nerve fibers or cells can be converted into an idea, an act of consciousness, is absolutely incomprehensible. …. Definite information regarding what takes place in the soul can neither be afforded by materialism, … nor by spiritualism, which would explain the material by the psychical. … Oscillation and vibration, all that is electrical and mechanical, are still not mental conditions, acts of thought. How they can be transformed to these is, indeed, a problem which shall remain unsolved to the end of time; and I believe that if today an angel from heaven came and explained all to us, our understanding would not even be able to comprehend it. [29], pp 5–6.

Griesinger had no use for those who would attempt religious cures for mental disease: “Religious instruction should not be withheld from any patient who desires and requires it; it would, however, oppose the first principles of mental treatment to enforce such instruction, or attempt to interest in it anyone who has no religion at heart. It would show total ignorance of the nature and circumstances of these diseases to aim at direct recovery by reforming or converting the patient by religious instruction” [29], p 490. He went further, saying that “Several medical psychologists would have the whole treatment of the insane be specifically Christian. But Jews also require the aid of the alienist, and his science….” [29], p 491.

The late nineteenth century saw the emergence of medical specialization, and physicians in both Europe and America began to treat individuals with psychological distress in the community who previously would have been understood by general physicians to have a neurosis (a term introduced by William Cullen in the late eighteenth century) or hypochondriasis (a term that, in the past, was used more broadly to include anxiety states). In the nineteenth century, an eighteenth-century concept, animal magnetism, formed the basis of mesmerism, founded by Anton Mesmer (1734–1815). This was a theory of an immaterial force influencing behavior that did not have a spiritual basis. Somewhat unexpectedly, the concept of animal magnetism became the basis for hypnosis demonstrations by Jean-Martin Charcot (1825–1893).

The widespread social influence of mesmerism is a complex historical event, since, like the similar phenomenon of phrenology, its social influence extended long after the scientific community seemed to have rejected it. In 1843, James Braid (1795–1860) published *Neurypnology or the Rationale of Nervous Sleep* in which he introduced the term hypnotism. Braid was an English surgeon and a student of mesmerism, concluding that hypnosis (i.e., the ability to use psychological techniques to effect improvement in physical conditions) had nothing to do with mesmerism. He and others had success in treating various disorders with their mental techniques, and by the 1880s, a number of physicians were involved in techniques that were the direct antecedents of psychotherapy [30], pp 356–359. The medical interest in how psychological phenomena were able to produce symptoms indistinguishable from physical disease states was great, and neurologists, in particular Charcot and his younger colleague Pierre Janet (1859–1947), elaborated theories to explain how unconscious influences might produce physical symptoms, especially in traumatized individuals [31], pp 340–341.

As cultural elites became more secular in the late nineteenth century, so did psychiatrists. Yet psychiatry itself is not inherently secular. In fact, by its nature, psychiatry is forced to come to terms with every aspect of human behavior and thought. Psychiatry, perhaps more than any other area of medicine, must acknowledge the widespread spiritual awareness expressed by most human beings.

By the late nineteenth century, psychiatry had begun to be established as a specialty in several universities in Europe and, as a medical specialty, focused on the relationship of disease to altered mental states. The Europeans who were interested in psychiatric problems were not seeing them as problems that were spiritual in

nature. Those studying mental disorders in the United States were, perhaps, more open to the question of how spiritual experience affected mental states.

It was in treatment, rather than diagnosis, that Christian concerns overlapped with psychiatric therapeutics in a way that it did not in other areas of medical therapeutics. In psychotherapy, in particular, where the physician psychotherapist was interacting with the patient in order to provide insight and hopefully relieve suffering, different approaches to the Christian faith led to different responses to the use of psychotherapeutics, as well as medical therapeutics. It was, of course, the emergence of these very specific psychotherapeutic approaches in the twentieth century that set the stage for subsequent developments.

Several developments laid the groundwork for the emergence of psychotherapy as a medical technique in the early twentieth century. In addition to the European interest in the role of hypnosis in treating hysteria, psychology as an academic discipline was established in the United States. Experimental psychology and psychiatry had both been strong in German universities during the mid-nineteenth century, and by the latter part of that century, Americans were also making widely recognized contributions.

William James (1842–1910), philosopher, psychologist, and physician, established the first academic department of psychology at Harvard in the 1870s. Then, in 1902, James published his Gifford lectures on the psychology of religion entitled *The Varieties of Religious Experience: A Study in Human Nature*, a book that even now can be considered the single most influential contribution that has been made so far to the psychology of religion. Among the many interesting aspects of this book is James's division of religious experience into that of the "healthy minded" and that of the "sick soul." James himself was not a Christian but had grown up in a broad-minded home and appreciated the positive impact that the Christian faith had on the lives of many people. He wrote extensively in *Varieties* on the phenomenon of conversion. This made the concepts of psychology of religion and psychotherapy palatable to a large number of clergy, at least in the United States. James seemed particularly attracted by what he understood to be the Lutheran and Methodist idea of conversion. He observed:

> Now the history of Lutheran salvation by faith, of methodistic [sic] conversions, and of what I call the mind-cure movement seems to prove the existence of numerous persons in whom — at any rate at a certain stage in their development — a change of character for the better, so far from being facilitated by the rules laid down by official moralists, will take place all the more successfully if those rules be exactly reversed. Official moralists advise us never to relax our strenuousness. "Be vigilant, day and night," they adjure us; "hold your passive tendencies in check; shrink from no effort; keep your will like a bow always bent." But the persons I speak of find that all this conscious effort leads to nothing but failure and vexation in their hands and only makes them two-fold more the children of hell they were before. The tense and voluntary attitude becomes in them an impossible fever and torment. Their machinery refuses to run at all when the bearings are made so hot and the belts are so tight.
>
> Under these circumstances the way to success, as vouched for by innumerable authentic personal narrations, is by an anti-moralistic method, by the "surrender" of which I spoke in my second lecture. [32], p 104.

James's approach to both the psychology of religion and psychology in general was attractive to a wide range of people and helped facilitate the acceptance of psychotherapy. In the early twentieth century, psychiatry adopted psychotherapy as a routine part of its therapeutic repertoire.

By the turn of the twentieth century, psychiatrists were starting to do psychotherapy not only in hospitals but also in outpatient settings. There was an increasing interest in psychopathic hospitals or reception hospitals. One was established in New York City at Bellevue Hospital in 1879. Others followed shortly thereafter in Albany, NY (1899); in Ann Arbor, Michigan (1901); in Baltimore (1908); and in Boston (1912). In Boston, especially, the new "psychopathic hospital" opened with the focus on short-term treatment and return home [33], pp 135–139. By the 1920s, an increasing number of psychiatrists were involved in outpatient services [34], pp 158–159. Increasingly, the responsibilities of psychiatrists included psychotherapy, and psychiatrists, especially when they began to be involved in outpatient care, began to enter territory that impinged on problems Christian clergy might also face.

By the early twentieth century, psychotherapy was becoming a therapeutic technique used by physicians and even clergy. Initially, there seemed to be no problem at all. Protestant liberals welcomed the insights of psychology and incorporated the new insights of psychotherapy into their pastoral healing work. The most notable is the Emmanuel Movement based at the Emmanuel Church in Boston and established by two ministers, Elwood Worcester and Samuel McComb [35], pp 4–36. The short-lived Emmanuel Movement, which began in 1906, brought popular attention to mental cures for emotional distress and may have helped set the stage for the positive American reception of Freud's 1909 lectures at Clark University in Worcester, Massachusetts [36], p 150.

William James's broad and sympathetic view of religion, conversion, and the positive aspects of religious belief certainly made it relatively easy to build bridges between clergy doing pastoral work and the field of psychology. Boston University School of Theology created the Department of Religious Psychology and Pedagogy in 1912. In the first decades of the twentieth century, several prominent seminaries offered courses in topics touching on pastoral psychology including the Chicago Theological School, Andover Newton Seminary, and Hartford Theological Seminary [37], pp 10–11.

More theologically conservative denominations also saw the value in the insights offered by psychology for the practicing pastor, though psychiatry was frequently ignored. Professor Gaines S. Dobbins, of the Southern Theological Seminary in Louisville, Kentucky, wrote knowledgeably in 1936 of the psychologists of his age. He observed how important it was for contemporary pastors to be prepared to support their congregations and people outside the church with a psychologically informed ministry. "Today," he wrote, "man is more pursued, more in jeopardy through engineering and steel monsters, than he ever was by giant lizards and sabre-tooth tigers. Vigilance and apprehension are literally the price of safety" [38], p 428–429. Dobbins spoke favorably of the contributions of William James to the concept of the "inner self." He believed the Baptist minister could offer the comforts of the Christian religion to those who were suffering mental distress and saw the

need for cooperation of ministers with psychologists and presumably psychiatrists, writing that "The minister and his associates are not to disparage the work of the trained scientist in dealing with both physical and mental illnesses. Nothing could be much more dangerous or disastrous than for ministers of religion and Christian laymen to set themselves up as 'mental healers,' going off almost certainly either into the excesses of fanaticism or the humbuggery of quackery" [38], p 435.

## The Mid-twentieth Century to the Present

### *Christian Responses to Developments in Psychiatry, Psychotherapy, and Psychoanalysis*

As the decades wore on, it became clear there was reason for concern about the theological implications of Freudian thought for psychotherapy. For example, in *Civilization and Its Discontents* (1930), Freud lamented the prevalence and power of religion, which he understood to be "...the system of doctrines and promises which … explains … the riddles of this world with enviable completeness, and … assures [the common man] that a careful Providence will watch over his life and will compensate him in a future existence for any frustrations he suffers here" [39], p 74. Freud thought that the general run of humanity needed such ideas, though he found religion embarrassing:

> The common man cannot imagine this Providence otherwise than in the figure of an enormously exalted father. Only such a being can understand the needs of the children of men and be softened by their prayers and placated by the signs of their remorse. The whole thing is so patently infantile, so foreign to reality, that . . . it is painful to think that the great majority of mortals will never be able to rise above this view of life. It is still more humiliating to discover how large a number of people living to-day, who cannot but see that this religion is not tenable, nevertheless try to defend it piece by piece in a series of pitiful rearguard actions. [39], p 74.

At times, psychoanalysts seemed to offer explanations for personal distress that were incompatible with Christian understandings, where forces from the unconscious that needed a therapeutic approach were blamed for aberrant behavior rather than sin. In addition, Freud and psychoanalysts often appeared to lump all religions into the same category, ignoring Christian claims to uniqueness.

Though Protestants were often accepting of the new psychology and psychiatry, a number of Roman Catholic leaders expressed grave misgivings. Perhaps the best-known Catholic critic of psychoanalysis in the English-speaking world was Bishop Fulton J. Sheen (1895–1979), who reached millions of people through his radio and television shows [40]. In his various talks and writings, Sheen saw Freud's emphasis on the centrality of sex in human thinking as gravely mistaken. He objected to the confusion psychoanalysis created about the nature of guilt, its critical stance toward Christianity, and its tendency to reach beyond the treatment of mental disorders and to make pronouncements in other areas. In *Peace of Soul* (1949), Sheen wrote:

> Christian faith and morals cannot possibly have any objections to a mental treatment whose aim is the restoration of the sick mind to its human end. But "psychoanalysis" becomes very wrong indeed when it ceases to be a method of treatment and pretends to be a philosophy. It steps outside its legitimate area as a branch of medicine and becomes dangerous when it is made the basis of a philosophical conception of man's nature, with such assertions as the statement that man is an animal and has no free will or that "religious doctrines are illusions." [41], p 89.

Sheen's approach was surely representative of many Catholic clergy of his time. In 1953, Pope Pius XII delivered an encyclical "On Psychotherapy and Religion" in which he condemned any element in psychotherapy which justified sin or denied the reality of sin, though he acknowledged that there was not only nothing inherently wrong in psychotherapy but that it "is capable of achieving precious results for medicine, for the knowledge of the soul in general, for the religious dispositions of man and for their development" [42].

With the social polarization that characterized the 1960s, the Christian response to psychiatry in the United States became increasingly complex. For Catholics, there was an increasing rapprochement with psychiatry and psychoanalysis. The anti-authoritarianism of American society as a whole had an effect on the role of psychoanalysis in psychiatry, since more leftist social movements rejected the authoritarian, paternalistic tone of the psychoanalytic establishment with its insistence on psychoanalysts being physicians and its hierarchical structure. As psychotherapeutic approaches within and without psychiatry became more diverse, and as the critique of psychoanalysis became identified socially with psychiatry in the minds of many during that era, some evangelicals began promoting a distinctly Bible-based view of psychotherapy that rejected not only psychoanalysis but most of the knowledge base of psychiatry as well.

Prior to the 1960s, many conservative Christians saw value in the insights of psychodynamic psychotherapy. But in the second half of the twentieth century, some American evangelical clergy began to adopt the anti-authoritarian rhetoric of the era to reject the legitimacy of psychiatry entirely. Jay Adams, a Presbyterian minister, began this movement in the 1960s, usually known as the "biblical counseling movement." Adams was frustrated with the psychoanalytically oriented counseling approach he learned about in his ministerial training [43]. He eventually met psychologist Hobart Mowrer, a psychologist who was a critic of psychoanalysis. In his book, *The Crisis in Psychology and Religion*, Mowrer faults psychoanalysis for a lack of attention to personal moral responsibility [43]. Mowrer invited Adams to participate in his Eli Lilly Fellowship Program at the University of Illinois where Mowrer was a professor of psychology. Adams spent the summer of 1965 observing and participating in Mowrer's clinical work at the state hospitals in Kankakee and Galesburg. This led to a period of reflection, after which Adams concluded that ". . . apart from those who had organic problems, like brain damage, the people I met in the two institutions in Illinois were there because of their own failure to meet life's problems. To put it simply, they were there because of their unforgiven and unaltered sinful behavior" [44], p xvi. Criticizing conservative Christians who believed that pastors should defer to mental health experts with respect to mental health

counseling, Adams asserted, "[T]he question never seems to be asked: is psychiatry a valid discipline?" [44], p 12. Mowrer encouraged Adams, and in 1966, Adams began experimenting with counseling in his own church using his new ideas about how counseling should work. He then left local church work entirely to teach "all aspects of pastoral care, counseling, and preaching" at Westminster Theological Seminary. Adams wrote several books, the most famous of which was the book *Competent to Counsel* in which he asserted the primacy of his Bible-derived counseling and critiqued a medical approach to mental illness. If the book were not so influential, it would be tempting to dismiss Adams out of hand. But the biblical counseling movement is still active in the United States and elsewhere. Though it has moderated its views of psychiatry and mental disorders [45], it continues to be suspicious of psychiatrists and other mental health professionals. Because of its American base, biblical counseling has broad influence in locations where there are Christian educational institutions [46].

In stark contrast to the drastic critique of psychiatry by conservative Protestant pastors was the response by psychiatrists who were Christians. Among Catholics, there were psychiatrists who saw no fundamental conflict between psychiatry and the Christian faith. In 1955, Francis Braceland, later the editor of the *American Journal of Psychiatry* and a devout Catholic, edited an impressive volume, *Faith, Reason and Modern Psychiatry: Sources for a Synthesis,* in which a variety of Catholic Christians, many of whom were psychiatrists and psychoanalysts, explained how psychiatry, psychoanalysis, and Christianity could fit together if the psychiatrist recognized the importance not only of unconscious forces but of the moral order as well. Problems came when psychiatrists ignored the realities of that order and promoted only "adaptability" [47], p ix.

Further, at least one prominent psychoanalyst, Gregory Zilboorg, developed a serious personal interest in spirituality, converting first to Quakerism and later to Catholic Christianity. Writing in 1962, Margaret Stone Zilboorg, Gregory's wife, recalled that her husband had been born in 1890 of Orthodox Jewish parents in Russia. Though educated as a physician and trained as a psychiatrist in Russia, when Zilboorg arrived in the United States as an immigrant at age 29, the only English words he knew were "Yes," "No," and "Bolshevik." However, he quickly learned the language and 3 months later gave a lecture in English. After that same lecture, Zilboorg was befriended by a professor of philosophy who was a devout Quaker, and soon Zilboorg himself became a member of the Society of Friends. Zilboorg had an ongoing interest in the relationship of psychoanalysis and religion. In 1953, after much consideration, he converted to Roman Catholicism. Though he had written his classic work, *A History of Medical Psychology* (1941), in such a way that one might believe he was hostile to the Christian faith, such was not the case.

Zilboorg, in an essay written in 1943, explained in detail that when Freud spoke authoritatively on religion, he was going beyond what he could do as a scientist. He wrote:

> Science has always concerned itself very little with questions of religion and morality. The scientist as a person . . . may or may not offer his own ideas on the relationship between his scientific observations and his religious feelings; he may be indifferent to the problem; he

> may even be antagonistic to religion. Whatever he feels in this respect he will feel not as a scientist but as a person . . . . The greatest scientist may be and usually is a very poor theologian and if an unbeliever, a rather naïve one. [48], p 39.

This understanding of how psychiatry, or any empirically based approach to human behavior, could be approached by Christians likely reflected the view of most Christians in psychiatry in the twentieth century. Psychiatry and theology were different areas of knowledge and used different methods of inquiry.

Zilboorg's views were shared by many Christians involved in psychiatry. In the United States in the 1950s, they formed organizations to facilitate mutual support and communication. The Catholic Guild of Psychiatry was established in 1956 [49], and the psychiatry section of the Christian Medical Society (now Christian Medical and Dental Associations) was formed in 1963, and both continue to be active groups. Their efforts and those of others in the United Kingdom, Germany, and the Netherlands led to an increased interest in elaborating the impact of religious faith on health. In 1986, David Larson, a psychiatrist at Duke, published with his colleagues an influential paper documenting the lack of serious research on faith and mental health in psychiatric journals [50]. They conducted a systematic analysis of psychiatric research published in four major psychiatry journals, including the *American Journal of Psychiatry*, *British Journal of Psychiatry*, *Canadian Journal of Psychiatry*, and *Archives of General Psychiatry* (now called *JAMA Psychiatry*), and assessed (1) the frequency of inclusion of religious variables in quantitative psychiatric research, (2) the robustness of statistical analysis, (3) the type of measure of religion used, (4) the conceptual basis for measurement of religion, and (5) the awareness of the scientific database on religious research. They found that quantitative psychiatric research rarely included valid research variables involving "religiosity," used methodologically inadequate measures of religion, and lacked knowledge of conceptual approaches to religious research that were used in other behavioral sciences like psychology and sociology. Since it was not uncommon for psychiatrists to comment on religion, and psychiatric literature often had an unstated bias that viewed religion as a negative factor in mental health, Larson et al. called for more research, especially since the existing research, inadequate though it was, suggested that religiosity usually promoted, not harmed, good mental health. Larson, collaborating with others, published at least eight other similar articles documenting the need for more sophisticated research into the role of religion in mental health. His interest, and that of others that followed, has led to a decades-long proliferation of serious medical research into the role of religion in behavioral health and healthcare.

## Conclusions

The history of psychiatry and Christianity is a history of two points of view that have at times clashed. This chapter makes clear that over many centuries, Christians involved in the care of mental disorders have used psychological, medicinal, and

religiously symbolic remedies for the treatment of mental illness. Despite the seeming "disenchantment" of the world after the Enlightenment, contemporary psychiatry has come to value spirituality. Though this appreciation is often expressed in non-Christian religious terms, cultural anthropologists have noted the value of folk healing in many psychological conditions. At least one medical anthropologist sees the use of Christian spirituality in psychiatric care as being a reassuring, positive development. Speaking of a group of self-identified Christian psychiatrists that he had studied, Gaines observed: "Such mental health care specialists are, in a sense, just what the (medical) anthropologist ordered: healers who share their patients' worldview with therapeutic techniques which are distinct from traditional Western biomedicine" [51], p 320–321. And so it may be that in the future, there will be a new appreciation for Christian spiritual approaches and psychiatry and Christian spirituality will, with time, peacefully co-exist.

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# Chapter 2
# Mental Illness Stigma in Christian Communities


**Jennifer Huang Harris**

## Introduction

In January 2020, the *Wall Street Journal* published a story discussing the difficulty ministers face in seeking and receiving mental health care. The article details the stories of several pastors who struggled with the pressures and isolation of their occupation and lost their jobs after disclosing a mental health diagnosis to church leadership. One of the stories is that of Scott Capp, an Illinois pastor who took a job fundraising for the Moody Bible Institute. He experienced suicidal ideation and was admitted to a psychiatric hospital for 10 days for bipolar affective disorder and was placed on administrative leave from work. He was fired the first day he returned to work. That same day, he posted a suicide note to Facebook mentioning the termination of his employment and then took his own life. Depression and burnout are common among pastors, says Tony Rose, a minister who also counsels other ministers. Churches and other religious organizations are some of the few places where employers can fire employees on the basis of mental illness. For all other organizations, patients are protected under the Americans with Disabilities Act (ADA), which states that employers may not discriminate on the basis of physical or mental impairments. However, in 2012, the Supreme Court ruled in favor of a "ministerial exception" to the ADA, so that churches can autonomously hire and fire ministers. "If you want to stay in ministry, the last thing [pastors] want to do is go public [with mental health problems]," Rose stated. This has created a culture of secrecy around mental health in the church [1].

The difficulty clergy have in seeking mental health care is symptomatic of the larger difficulty Christians face in seeking and receiving mental health care due to

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stigma within church communities, which results from a confluence of two factors: the mental health stigma prevalent in the culture at large and the mental health stigma particular to Christianity. Even though studies suggest that regular church attendance is correlated with lower rates of depression and suicide generally [2, 3], the burden of mental illness within churches is still high. In 2014, LifeWay surveyed 1000 Protestant pastors about mental health problems. The study found that 74 percent knew personally one or more people who had been diagnosed with clinical depression and 23 percent reported having personally struggled with mental health issues themselves [4].

In this chapter, we will review sociological theories of why stigma exists, such as in-group and out-group behaviors and attribution theory, and then examine how these apply to Christian communities. We will also examine how philosophical and theological conflicts regarding the validity of psychiatric diagnosis, the nature of mental illness, and the beliefs about treatment contribute to mental illness stigma in church communities. Finally, we will discuss recommendations for overcoming stigma and moving toward compassion.

## What Is Stigma?

According to the *Merriam-Webster Dictionary*, *stigma* is derived from Latin, meaning "mark, brand." "Its first use in English referred to a scar left by a hot iron. In modern use the scar is figurative: stigma most often refers to a set of negative and often unfair beliefs that a society or group of people have about something" [5].

One of the first researchers to examine the phenomenon of stigmatization was the influential sociologist Erving Goffman, who in his book *Stigma: Notes on the Management of Spoiled Identity* defined stigma toward an individual as an "attribute that makes him different from others in the category of persons available for him to be, and a less desirable kind -- in the extreme, a person who is quite thoroughly bad, or dangerous, or weak… He is thus reduced in our mind from a whole and usual person to a tainted, discounted one" [6]. More recently, sociologists have suggested that stigma is a label that others affix to an individual rather than a quality or characteristic possessed by the individual.

It is often assumed that stigma is created by an individual, e.g., a bully. However, stigmatization is not a phenomenon that occurs at the level of the individual as a reflection of personal preferences, choices, or rejections, but rather a social process of labelling and stereotyping at the group level [7]. Stigma describes the tendency of the majority to distance themselves from and devalue a disparaged group possessing a stereotyped, generalized set of characteristics [7]. Stigmatization can result in avoidance, punishment, exploitation, or aggression toward the stigmatized. *Social distancing*, or people's willingness to avoid, is a widely used measure of stigma, because the avoidance is damaging and distressing and disruptive to an individual's life [8, 9]. Understanding stigmatization as a social process makes it

possible to examine what factors in communities systematically contribute to stigma and can therefore be targeted for improvement.

Mental illness stigma results in a wide range of repercussions for the stigmatized. Individuals can suffer rejection by family, communities, employers, and/or housing authorities [10, 11] that limits their ability to live independently beyond the impact of the mental disorder itself [11]. The term *self-stigma* is used to describe the internalization of the devaluation experienced by individuals who are stigmatized. Self-stigmatizing individuals feel different, devalued, and that they do not belong. Self-stigma can worsen mental health outcomes and lead to increased functional impairment. The more individuals with mental illness feel stigmatized, the lower their self-esteem, life satisfaction, and social adjustment [6, 8]. Self-stigma is also a major obstacle to recovery, as it may prevent some from seeking help or decrease adherence to treatment [8]. A study by McGuire and Pace suggested that Christians had a significantly higher degree of self-stigma toward depression compared to non-Christians and that evangelical Christians in particular possessed the highest degree of self-stigma [12]. However, it is important to note that not all individuals who are stigmatized experience self-stigma and that some demonstrate resilience despite self-stigma [10].

## Causes of Mental Illness Stigma

Although certain stigmas may be particular to a culture, such as stigma against obesity in Western cultures, there are other types of stigma which are remarkably consistent across cultures and times, such as stigma against the physically deformed and mentally ill [7]. There are several theories as to why the mentally ill in particular face stigmatization.

(i) *Self-esteem (or ego/group justification)*: Traditionally, stigmatization has been assumed to be a problem for particular individuals, who, due to characteristics such as narcissism, ethnocentrism, and/or authoritarianism, stigmatize as a way to elevate themselves [13]. Devaluing another person protects the stigmatizer's own self-esteem and their social status [14]. As many mental illnesses carry low self-evaluation and low social status, the mentally ill may be easy targets for this type of stigmatization.

(ii) *Social power/system justification*: On a structural level, another theory [15] suggests that stigmatizing others allows people to justify the social, economic, and political systems in which they live (e.g., systemic injustices such as slavery).

(iii) *Innate in-group/out-group behavior*: More recent research on stigma suggests that the stigmatization is a more morally neutral process, a natural consequence of people's cognitive processing and limited exposure to social experiences [13, 14]. Much stigmatization is not a conscious process but occurs automatically [10]. Labelling and categorizing people seems to be a manifestation of a

cognitive process that occurs preconsciously, a cognitive heuristic or mental shorthand that allows individuals to make quick assumptions (i.e., stereotypes), freeing up their attention to process other matters (i.e., as discussed in Daniel Kahneman's *Thinking, Fast and Slow*) [16]. Stigma may play a natural role in social groups by reinforcing group behavior and protecting it from threats to the community. It can protect communities by isolating individuals whose behavioral abnormalities are a symptom of contagious illnesses, perceived or otherwise, such as rabies.

Even as children, we have an innate sense of "us" versus "them" or "in-groups" versus "out-groups." People are wired cognitively to have a positive bias toward members of their in-group and to focus on individual identities and positive traits of in-group members. On the other hand, they have a negative bias toward members of the out-group, tend to negatively stereotype out-group members, and portray them homogeneously and negatively [11]. The behavioral abnormalities of those with mental illness may mark them as different, leading to their being labelled as part of an out-group.

From a group perspective, the mentally ill may be stigmatized due to their perceived threat and perceived ability to contribute less to the group.

1. *Fear of physical harm*: Well-publicized examples of unpredictable and violent behavior heighten fear that the mentally ill, particularly those with psychotic disorders, will threaten one's physical safety. In truth, the risk of violence is increased in only a few disorders – antisocial personality disorder and psychopathy, intermittent explosive disorder, alcohol and substance abuse, and psychosis involving persecutory delusions of being under attack [11]. On the whole, people with mental illness are more likely to be the victims of violence, rather than perpetrators [17].
2. *Threat to mental stability*: The behaviors and feelings of those with mental illness may threaten one's own belief in being in control of one's own mind and behavior [11]. There may be a fear that these emotions are contagious and a belief that distancing oneself from these individuals can preserve one's own sanity.
3. *Inability to cooperate and contribute to the social group*: On a group level, individuals are valued who have high social capital and can socially reciprocate and contribute to the group [7, 15]. Those with mental illness, who may offer less in these terms or demonstrate behaviors deviating from the group norms, are often ostracized from participating in the group [18].

All of these forces operate in larger society, and they likely also act within church communities as well. However, there are distinctive features of Christianity that may exacerbate mental health stigma, grounded in history, conflicting belief systems, and different explanatory models.

## Stigma in Churches

In his book *The Nature of Prejudice* (1954), the psychologist Gordon Allport acknowledges the complex relationship between stigma and religion when he states that religion "makes prejudice and it unmakes prejudice…. Some people say the only cure for prejudice is more religion; some say the only cure is to abolish religion" [19].

The relationship between Christianity and psychiatry has not always been marked by antipathy. As Samuel Thielman discusses in the chapter "The Fraught History of Psychiatry and Christianity," at points during history, churches have been actively involved in the care of the mentally ill, establishing asylums for the mentally ill, and working closely with physicians. The rift between Christianity and psychiatry has grown over time to the detriment of Christians suffering from mental illness.

Clergy are often the first people to whom patients with mental illness turn for help, but their requests often go unmet. In a 2007 survey, one researcher found that of 293 individuals who approached their church asking for help for themselves or their loved ones, 32.4% were told that their loved ones did not have mental illness or that it was due to spiritual or demonic causes. As a result, 14% of those individuals reported this interaction had weakened their faith, and 12.6% reported they were no longer involved in their church because of this interaction. In a subsequent follow-up study, these researchers found that of 85 study participants who approached their church for help with mental illness, most were hoping for guidance or counseling. Nevertheless, 57.6% reported that their church was not at all involved in their care. Furthermore, 41% reported that someone at their church denied that they had a mental illness, and 28% reported that someone at their church recommended they stop taking medications [20].

Certain denominations seem to have a higher prevalence of stigma against the mentally ill. Researchers have found that dismissal of a mental illness diagnosis was more common in charismatic churches [20]. In addition, churches which were conservative on doctrinal issues and the interpretation of scripture also tended to dismiss mental illness diagnoses [20]. However, there is a distinction between churches that adhere to religious orthodoxy and fundamentalism. Orthodoxy refers to acceptance of the doctrine central to the Christian faith (e.g., Jesus Christ was the divine son of God). Fundamentalism, on the other hand, refers to beliefs that one's religion is infallible, unchangeable, and the only true religious path. In one study, religious fundamentalism, but not orthodoxy, was associated with more negative attitudes toward individuals with mental illness [21]. Fundamentalist churches tend to be intolerant of ambiguity and consider all mental health issues to be spiritual [22]. From a sociological perspective, fundamentalist groups are often authoritarian [18] and may tend to reinforce tendencies toward in-group versus out-group judgments, which also applies to mental illness [21].

## Causes of Stigma in the Church

Spiritual and professional mental health approaches overlap in the problems they attempt to address, and the conflict between these approaches and belief systems is also an important contributor to mental illness stigma. Some of the primary conflicts concern the validity of psychiatric diagnosis, different explanatory models for the causes of mental distress, and different views regarding treatment.

### *Validity of Psychiatric Diagnosis*

In the 2007 study cited earlier, 32.4% of people with mental illness who sought help at a church were told that they did not have mental illness [20]. This doubt regarding the validity of psychiatric diagnoses may have originated historically outside the church. In 1961, Thomas Szasz, the psychiatrist considered to be the father of the antipsychiatry movement, stated in his book *The Myth of Mental Illness*, "Since theocracy is the rule of God or its priests, and democracy the rule of the people or of the majority, pharmacracy is therefore the rule of medicine or of doctors" [23]. He considered psychiatry to be the secularization of religion that was used to subjugate people. Invoking system justification theory, he maintained that by calling people diseased, psychiatry attempts to deny their responsibility as moral agents in order to better control them. Like others, he criticized psychiatry as a secularized religion and considered psychiatrists to be modern priests [24].

The antipsychiatry movement inspired a backlash against psychiatry within churches as they attempted to reclaim psychiatric problems as spiritual ones, which had been inappropriately pathologized. As biblical counselor and theologian David Powlison observed, "Emotional and behavioral ills of the soul that once registered dislocations in a moral agent's relationships to God and neighbor were re-envisioned as symptomatic of a patient's mental and emotional illness. Worry, grumbling, unbelief, lovelessness, strife, vicious habit, and deceit came to be seen through different eyes, as neurotic anxiety, depression, inferiority complex, alienation, social maladjustment, addiction, and unconscious ego defense" [25].

Another aspect of the conflict over the validity of psychiatric disorders can be considered territorial or jurisdictional. In his book *The System of Professions*, the sociologist Andrew Abbott describes how, up until the late nineteenth century, people struggling with personal problems ranging from anxiety or depression to psychosis turned to clergy for help. Over time, other professions arose that laid claim to these issues – the neurologists, the psychiatrists, the psychologists, the social workers, and even the gynecologists (as many psychiatric conditions in women were initially thought to be related to the female reproductive system). However, as the clergy failed to keep pace and develop a theological framework for explaining these problems, "under renewed threats from outside professions, the loose neurological construction of personal problems turned into the modern concept of

neurosis as a psychically generated, psychically diagnosed, and psychically treated phenomenon" [26].

Perhaps one of the clearest examples of jurisdictional conflict is the "disease" of homosexuality, which was once considered a psychiatric disorder [27]. The depathologization of homosexuality in 1973, and its removal from the second edition of the *Diagnostic and Statistical Manual*, calls into question whether homosexuality fit the definition of disease in the first place. Is homosexuality a medical disease, a moral issue/sin, or perhaps a normal variation of human behavior [28, 29]? As psychiatry has laid claim to conditions that traditionally fell under religious and moral jurisdiction, such as oppositional defiant disorder, antisocial personality disorder, and addictions, some churches have questioned this process and the legitimacy of psychiatry itself.

## *Explanatory Models and Attribution Theory*

Stigma theory also posits that stigma results from what is perceived that individuals did to bring the condition on themselves. *Attribution theory* holds that "causal ascriptions for an actor's behaviors lead to characteristic emotional, attitudinal, and behavioral responses to the actor in question" [11]. Put another way, stigma results when negative behaviors are thought to be under personal control. In a 2007 study by Feldman and Crandall, researchers found that *personal responsibility* for the mental illness was the greatest predictor of stigma, compared to dangerousness, rarity, treatability, or other factors [8]. When a person is thought to be responsible for the onset of the illness, this leads to greater social rejection. Weiner's theoretical model of attribution-affect-action [30] suggests that this occurs because personal responsibility for a negative outcome elicits anger, which leads to low sympathy and high levels of avoidance and punishment.

### Spiritual Explanatory Models

Churches hold several different explanatory models for mental illness, several of which emphasize the role of personal responsibility. The spiritual explanatory models could be divided into the following categories:

1. The experience of psychiatric illness itself as sin

The association of psychiatric symptoms with sin stretches back centuries ago in Christian history. According to the treatise by monk John Cassian in the fifth century AD, depression was considered one of the deadly sins [31]. In the Fourth Lateran Council in 1215, sorrow, laziness, weariness, spiritual negligence, lack of joy in general, despair in general (and particularly of one's own salvation), doubt, grief, tedium, and hatred of life were all considered to be sinful [31]. Later psychiatrists would recategorize much of what used to be considered sinful behavior as a

manifestation of mental illness. However, within Christianity, the negative emotions such as depression and anger have continued to be associated with sin [32]. In addition, the traditional Roman Catholic stance was that suicide is a mortal sin and people who died by suicide would be denied a Christian burial, although this stance has softened over time [33]. Christians continue to debate whether suicide is an unforgiveable sin, and this contributes to the distress of individuals struggling with suicidal thoughts, as well as of family members of those who complete suicide.

Some interpret the biblical commands to "Rejoice always" (1 Thessalonians 5:16) or "Be anxious for nothing" (Phil 4:6–7) to mean that the emotions of sadness or anxiety are sinful. Christians may believe that if a person is walking closely with God, he or she should not be depressed or anxious and should experience hope and joy whatever the circumstances. This belief is essentially a rehashing of the Greek philosophy of Stoicism, which teaches that emotions like fear or envy or passionate love of anything whatsoever arose from false judgments and that the sage – a person who had attained moral and intellectual perfection – would be immune to misfortune [34]. However, when the full scope of the Bible is considered – the Psalms and Lamentations and in particular Jesus' agony in Gethsemane – it is clear that Stoicism is not biblical. There is a place for both joy and weeping in the Christian faith (Romans 12:15).

2. Psychiatric illness as evidence of punishment from God for sin

Research suggests that people tend to assume that there is justice in the world and that those who are suffering brought it upon themselves [35]. We see this operating in the Book of Job, when his friends accused him of sin and claimed that his suffering was deserved (Job 8:2–6, Job 22:5). By this logic, persons with mental illness can be seen as experiencing punishment from God for sinful or moral weakness [36].

In some cases, sinful actions may precede psychological distress. If one has committed a crime, anxiety about being discovered would be a natural consequence, and depression may follow if one ends up being punished for the crime. However, guilt is not always an indication of sin. Feelings of guilt occur both as a consequence of sin and in psychiatric conditions such as major depressive disorder, anxiety disorder, obsessive-compulsive disorder, or delusional disorder. This may be confusing for people struggling with guilt due to their mental illness, who may begin to wonder if they have some hidden sin. External accusations of sin may worsen their prognosis [37].

Perhaps a more common variation on the idea that mental distress is sin is the belief that psychiatric illness is a failure to implement spiritual practices such as prayer for healing, Bible study, attending religious services, etc. Christians may believe that if a person were to implement these practices and attain "spiritual maturity," they would not suffer feelings of depression, anxiety, etc. [36]. However, it is possible that difficulty engaging in spiritual practices may not be the cause of the mental illness, but the result. Mental illness may impair concentration, decrease energy and motivation, and cause social withdrawal, which may hinder engagement in spiritual practices.

3. Psychiatric illness as demonic

The belief that mental illness is demonic in some form is still prevalent among many Christians [36], not only for schizophrenia (where hallucinations and self-dialoguing may be suggestive of demon possession) but for other mental illnesses as well. In a study of 126 Protestant Christian participants, Hartog and Gow found that 38.2% of participants believed that demonic oppression/influence was a cause for major depressive disorder and 37.4% that it was a cause for schizophrenia [22].

It is important to clarify what is meant by "demonic etiology." (a) Demon *possession*, in which a person is taken over by a demon, should be distinguished from (b) demonic *oppression*, in which a person might experience temptations, thoughts, or feelings which are considered Satanic attacks, and from (c) a more general sense of demonic origin in which all that is evil and injustice in the world is considered Satanic in origin. These categories carry different implications as to whether someone believes that a person needs a treatment such as exorcism [38, 39]. One possible reason why a person with mental illness might be receptive to the idea that they are demon possessed is that mental illness can impair motivation, cause obsessional thoughts, and increase compulsions and as a result cause a person to feel that they lack free will.

## Medical Explanatory Model

In order to counter the stigma that may occur with this spiritual model for mental illness, many churches have attempted to teach their congregations a medical model for mental illness [37, 40]. This falls in line with educational efforts in the broader culture to reduce the stigma of mental illness which proclaim that "mental illness is an illness like any other" [41, 42] and that mental illness is a brain disease [43].

Attribution theory posits that if behaviors are thought to be due to factors outside an individual's control, others will be more empathetic and compassionate. According to this theory, if mental illness is a medical disease and not a moral failing, it invites compassion and treatment rather than judgment and condemnation. Focusing on the medical explanations for mental illness is assumed to reduce stigmatization because the causes exist outside of personal responsibility, and a person cannot be blamed for the illness.

However, research suggests that adopting the medical model may not reduce stigma. Although medical explanations have been shown to reduce blame, they can have the unintended consequences of increasing fears of unpredictability and violence [42] and provoke harsher treatment of the mentally ill [43, 44]. In other words, when a brain disease is thought to be so severe that the person cannot be held responsible for their actions, this increases fear that the person may lose control and be violent.

What this suggests is that personal responsibility and blame may be less fundamental to stigma than in-group and out-group dynamics. As Hinshaw and Stier state in their review of mental illness stigma, "when the disease model is applied to the

brain, the assumption is that the person is incapable of judgments, reason, autonomy – that their personhood is negated" [42]. The medical model actually worsens the divide between "us" and "them," by suggesting that the other person is fundamentally different or less human [43]. Research has suggested that the medical model may increase self-stigma within the individual (e.g., when patients state "I shouldn't have children because I'm afraid I'll give them my bipolar disorder"). A focus on medical causality may decrease hope and induce pessimism about recovery [11, 45]. Perhaps one of the starkest examples of the failure of the medical model was the systemic extermination of the mentally ill (among the many other stigmatized groups) by the Nazis, justified on the basis that their mental illness was due to supposed genetic inferiority [11, 46].

The current reductionistic tendency in psychiatry tends to emphasize neurochemical (e.g., a "chemical imbalance") and genetic explanations for mental illness and neglect other factors. This is understandable from a jurisdiction perspective, as psychiatry seeks to legitimize itself as a medical specialty and pharmaceutical companies seek to justify their treatments (e.g., "anti-depressants restore the chemical balance in the brain") [26]. Mental illness, however, is by nature multifactorial, with biological, psychological, social, and spiritual causes [42]. There are benefits to emphasizing a more multifactorial model for mental illness. A medical perspective is useful because it reframes the mentally ill not merely as sinners, but as sufferers [47]. However, a spiritual perspective is vital to confer meaning and dignity to the suffering and to emphasize personal agency. And a psychosocial perspective makes mental illness more understandable as a natural response to difficult life circumstances [42, 43]. Research has shown that emphasizing psychosocial causes such as trauma and environmental stressors can decrease stigma and increase compassion [42, 45]. Viewed in this manner, mental illness is still a result of "sin," but of the sins that are present in our communities and evident in the brokenness and injustice present in our world [48].

## *Beliefs About Treatments*

In 2013, LifeWay Research conducted a brief telephone survey of 1001 Americans about mental illness. Thirty-five percent agreed that "With just Bible study and prayer, alone, people with serious mental illness like depression, bipolar disorder, and schizophrenia could overcome mental illness." Half (50%) of participants 18–29 years old believed that prayer and Bible study could overcome mental illness, though that number dropped to less than 30 percent for those aged 55–64 years. Likewise, 48% of evangelical, fundamentalist, and born-again Christians believed that prayer could overcome mental illness, whereas only 27% of other Americans agreed [49]. Regardless of beliefs about the causation of mental illness, beliefs about the solution to mental illness influence help-seeking behaviors and both compliance with and response to treatment [48].

Beliefs about treatment can be summarized in three categories:

1. Belief in spiritual causality and need for spiritual treatment

Those who believe that mental illness has only spiritual causes typically suggest that the treatment should be only spiritual as well, often discouraging members of their church from seeking secular psychiatric help, whether medication or psychotherapy [36]. Belief in underlying spiritual causes also manifests in skepticism toward psychological theory and debate as to how to integrate psychological theory with psychotherapy derived from the Bible [25, 50].

2. Belief in medical causality, but belief in spiritual treatment

There are also some who would acknowledge that there are medical contributions to mental illness but would consider even medical conditions to have fundamentally spiritual causes. This would describe, for example, the tradition of faith healing more common in Pentecostal denominations [38, 39] as exemplified by televangelists like Oral Roberts or Aimee Semple McPherson. Those holding this belief would suggest that only spiritual treatment be utilized for both mental and physical illnesses.

3. Belief in medical causality and medical/psychotherapeutic treatment

Many Christians and denominations accept the view that mental illness has medical causes and therefore that medical treatment has an important place. A survey of 1031 United Methodist clergy in Indiana and Virginia found that most held the view that biological causes were more important than psychosocial or spiritual causes and most agreed that medication was helpful [51]. Another survey found that Roman Catholics tended to have less skepticism about secular mental health treatments, compared to Christians who identified as Protestant or nondenominational [36, 51].

## *Cultural Factors*

The stigma of mental illness within churches may be a symptom of a larger discomfort within the American church regarding suffering and brokenness. Marcia Webb has theorized that this may be a result of the American Dream, which holds that success is a matter of hard work, coupled with the Protestant work ethic, which holds that God rewards obedience with success [36, 47, 51]. This is made even more explicit in prosperity theology, which holds that if people have faith, God will bring them health and financial blessing. When confronted with mental illness, the response in such a Christian culture is that sufferers should "pull themselves up by their bootstraps," because not only are the mentally ill lacking in willpower, but they are deficient in faith to claim God's blessing [48]. This view might not be made explicit in the majority of churches, but an underlying impatience with those suffering from mental illness is still prevalent, as well as the hope that living faithfully will guarantee joy and peace. The underlying theological assumption is that once one becomes a Christian, one will not experience suffering, setbacks, or losses.

But even a casual reading of the New Testament makes it clear that a life following Christ will be a life of suffering (1 Peter 4:12, James 1:2, John 15:20, John 16:33, 2 Cor 11:23–29, 2 Cor 12:7–10).

## *Practical Difficulties*

There may be a simpler reason also for why those in the church give the mentally ill a wide berth. As a pastor friend reminded me, "Caring for the mentally ill is hard." A 2014 LifeWay study found that many clergy wanted to help those with mental illness, but about quarter of clergy (22 percent) were reluctant to help those with mental illness because it takes too much time [4]. For busy clergy who face many demands on their time, any reluctance may be exacerbated by a lack of education and training on how to work with the mentally ill or how to collaborate with mental health professionals.

## *Overcoming Stigma*

1. Equipping

Some studies suggest that clergy see more mental illness than both psychiatrist and psychologists combined, and in that respect, clergy are serving as frontline mental health workers [52]. If that is the case, clergy and ministry leaders need to be equipped to identify and work with mental illness. In Farrell and Goebert's 2008 study, 55% of pastors felt their training was inadequate to recognize mental illness, but regardless of the amount of training, most felt compelled to counsel parishioners seeking their guidance. Parishioners with mental illness were not referred to psychiatrists in part because of clergy's inability to identify serious mental illness [53]. Many seminaries have started to offer training in mental illness in order to meet this need. In addition, increasing collaboration with mental health professionals would be helpful, and this may include maintaining referral lists with trusted mental health providers in the community. According to the 2014 LifeWay study, although two-thirds of clergy reported keeping such lists, only a quarter of parishioners were aware of this [4].

2. Education

Interventions to reduce mental illness stigma in churches have not been well studied. However, the research that has been done on interventions to reduce HIV/AIDS stigma in churches suggests that a combination of strategies that educate and provide personal contact with the stigmatized is the most effective to reduce stigma [54]. In order to confront mental illness stigma, clergy and churches need to be educated about mental illness and its multifactorial causes as well as treatments.

A focus on strategies emphasizing both (a) psychosocial and biological causes and (b) individual and family responsibility for securing treatment tends to be the most productive in reducing stigma [11]. Education about the role of personal responsibility and spiritual causes needs to be addressed. But a culture shift is also important in order to contextualize the discussions of mental illness. Open discussions about mental illness from the pulpit in sermons, in prayer, and in small group gatherings, for example, can help break the silence around mental illness in the church. Furthermore, the inaccuracies of the prosperity gospel need to be confronted, and, in its place, a theology of suffering needs to be developed.

3. Personal experiences with people with mental illness

Multiple studies demonstrate that the most effective way of reducing stigma is through social contact with someone who struggles with mental illness [55]. This provides a way to enhance empathy, particularly when the contact is informal, casual, and regular, and involves shared goals and rewarding activities [11, 55]. Personal experience with a person suffering from mental illness bridges the divide and the "other-ness" of stigma. In churches that are more authoritarian in structure, leadership should begin at the top, with openness and honesty from clergy and ministry leaders about their own struggles and the creation of a culture of support, rather than condemnation of mental illness. It might also involve opportunities to engage and interact with those suffering from mental illness in small groups, social settings, and volunteer service. Just as churches pray for church members fighting cancer or recovering from heart attacks, churches can lift up church members struggling with acute mental illness in corporate prayer. Stigma fades and compassion grows when the "stranger" becomes the familiar, a person with a face and a story.

## Conclusion

The plural form of the word stigma is stigmata, and according to *Merriam-Webster Dictionary*, it "typically refers to bodily marks or pains resembling the wounds of the crucified Jesus." This is the irony of stigma within church communities. Stigma arises due to self-interest, is driven by fear, and serves to distance and devaluate. Mental illness stigma is exacerbated by spiritual beliefs that mental suffering is evidence of sin or demonic activity and is exacerbated by beliefs that one only needs to pray more, or have more faith, and the distress will go away. But at the center of the Christian faith is a man who crossed the divide of stigma. He touched and broke bread with the stigmatized – women, Gentiles, prostitutes, tax collectors, lepers, sick, and demon possessed. In order to reconcile the world to God, Christ Himself became an outcast and bore the stigmata – the mark of the outcast and the criminal – by dying on a cross. In doing so, He claimed the strangers as sons and daughters, He claimed the condemned as forgiven, and He claimed the outcasts as those loved by God. He loved the outcast and the stigmatized and made them His own. What would churches look like if they were to follow His lead?

## Helpful Resources

- American Psychiatry Association – *Mental Health: A Guide for Faith Leaders* (www.psychiatry.org/faith);
- Caring Clergy Project, from the Interfaith Network on Mental Illness (http://inmi.us/for-clergy/);
- National Association for the Mentally Ill, FaithNet (https://www.nami.org/faithnet)

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# Chapter 3
# Psychotic Symptoms and Spiritual Phenomena


**Christopher C. H. Cook**

## Introduction

The relationship between psychotic symptoms and spiritual phenomena is a complex and controversial one, both within Christianity and more widely. On the one hand, there are those who would reduce more or less everything to neuroscience, finding little that is of spiritual value in psychosis. On the other hand, there are those who would see psychosis as providing valuable and privileged insights into spiritual truths. Somewhere in between these extremes, many have emphasised that spiritual and psychotic experiences can look very similar but that there are differences and/or continuities [1]. Some emphasise the need to distinguish between authentic spiritual experiences on the one hand and psychopathology on the other [2]. Others emphasise the overlap more than the differentiation [3]. Whatever position one may adopt within these debates, it can be argued that there is a spirituality to be found within all experiences of mental disorder, including psychosis, and that – from a Christian perspective – mental health is (or should be) a central concern of the Christian gospel [4].

In this chapter, I will consider briefly the current psychiatric debate about the proposed continuum of psychosis and psychosis-like symptoms in the general population as a context for addressing some of the important issues in relation to psychotic symptoms and spiritual phenomena within Christianity. I write from the dual perspectives of psychiatrist and Anglican priest and drawing on my experience over the last 17 years as a member of the executive committee of the Spirituality and Psychiatry Special Interest Group at the Royal College of Psychiatrists.

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## Psychosis and Psychotic Symptoms

The psychoses are a group of psychiatric disorders which are marked in some way by dislocation from the rational social consensus as to the nature of reality. The symptoms usually taken to be reflective of this dislocation are principally disorders of thought and perception, notably delusions and hallucinations [5, 6]. Such symptoms are subjective, and there are no objective tests by which psychotic disorders may be diagnosed. Diagnosis therefore relies on careful attention to phenomenology.

In recent years, there has been increasing recognition that the symptoms that were historically taken to be pathognomonic of psychosis have correlates in the general population amongst ordinary people who have no psychiatric diagnosis and who are apparently going about their lives without distress or impediment. Thus, for example, auditory verbal hallucinations are experienced – according to some surveys – by a quarter of the population at large [7]. Whereas delusions and hallucinations were traditionally understood to be binary phenomena, either present or absent, it is also now recognised that they may in fact be amenable to rating as continuous variables. For example, delusions may be rated according to the degree of severity [8]. At the lesser end of severity, we might locate overvalued ideas, not held with delusional intensity and more open to discussion. This has further led to the suggestion that there may be a psychosis "continuum", within which certain people, displaying subclinical symptoms of psychosis, may be more vulnerable to developing a diagnosable psychotic disorder, given sufficient environmental stress [9]. "Psychosis-like" symptoms are taken to be a marker for high risk of developing psychosis [10].

The continuum hypothesis remains controversial. Continuity of phenomenology does not necessarily imply continuity of underlying mechanisms [11]. Scientific evidence for an underlying continuum is largely lacking [12], and it promotes a pathologising of certain beliefs and experiences which are neither distressing nor disabling. Amongst the wider spectrum of beliefs and experiences that it calls into question are those associated with religious belief. For example, members of new religious movements have been found to score more highly on measures of delusional ideation than non-religious and Christian control groups [13]. The religious experiences of Christians, and others, could easily be seen as a part of the psychosis continuum, although it has also been argued that there is diversity within the continuum and that the hallucination-like experiences of (for example) Christians at prayer are not evidence of vulnerability to psychosis [14]. Religious fervour may be difficult to distinguish from psychosis but should always be evaluated within the cultural norms of the religious tradition concerned.

Psychosis-like symptoms also occur in a wide range of non-psychotic mental disorders. For example, hallucinations may be experienced within the context of post-traumatic stress disorder, dissociative identity disorder, and borderline personality disorder.

## Psychotic Symptoms in the Bible and Christian Tradition

There has been a long history, in some circles, of assuming that certain religious phenomena in biblical and medieval times were manifestations of psychosis or psychotic-like experiences. For example, it has been proposed that Abraham was deluded [15] and that Ezekiel was suffering from schizophrenia or schizo-affective disorder [16–19] (see also rebuttal of this view [20]). There has been ongoing debate, for a century or more, concerning the possible diagnosis of Jesus as suffering from psychosis [21, 22]. In the literature on medieval religious experiences in Europe, it has been suggested both that demonic possession was actually a manifestation of psychosis [23] and also that various saints and mystics may have been psychotic [24–26]. In a more positive vein, religious figures are sometimes taken as good examples of non-pathological voice hearing. For example, Watkins [27] lists Jesus and St. Paul amongst other "famous voice hearers". However, all of these proposals are, in the end, highly speculative. We cannot go back in time to interview Ezekiel or St. Paul. History has bequeathed to us manuscripts which are often of uncertain authorship and which employ a variety of literary devices and genres to communicate theological and hagiographical themes according to non-scientific historical and cultural criteria that were very different than ours. Whether or not any of these figures had experiences that we would recognise as "voice hearing" is highly debatable. Psychiatric interpretations often tell us more about the modern author than they do about the historical figure.

The biblical record is, however, deeply important to Christians. When contemporary psychiatrists pathologise biblical figures, they create a barrier for their Christian patients to overcome. "How can I talk to my psychiatrist about my faith?", they might well ask, if he/she considers that it is all based on mental illness? More positively, but also with potential for creating diagnostic confusion on the part of some psychiatrists, Christians base their religious expectations upon scripture. If God spoke to Moses, St. Peter, and St. Paul, then why should He not speak to people of faith today? If Jesus heard a voice at His baptism and conversed with Satan in the wilderness, then why should voices, demonic or divine, not be a part of contemporary Christian experiences [21]? Important research is emerging which suggests that these expectations are often fulfilled as Christians go about their daily lives of prayer and service.

The Bible also contains stories of mental illness, including psychosis. In the Book of Daniel (4:33), Nebuchadnezzar, under God's judgement, experiences an episode of mental disorder within which he is excluded from human society, eats grass, and fails to care for himself. When this episode passes, Nebuchadnezzar's reason is said to return to him (Daniel 4:34, 36). In the New Testament, the story of the Gerasene demoniac provides an account of someone who appears to be suffering from what we would recognise as a psychotic disorder.[1] Like Nebuchadnezzar, he is also excluded from human society. He has to be restrained; he goes about naked, howling, self-harming, and sleeping poorly. When Jesus has cast the demons

[1] Mark 5:1–20, Luke 8:26–39, Matthew 8:28–34. See a more detailed discussion in [28].

out of him, he is restored to his "right mind" (Mark 5:15). These stories, written thousands of years ago, present psychosis according to a very different worldview than ours, but within a framework of Judeo-Christian tradition continuous with that which now also shapes contemporary Christian faith. Whilst, on the one hand, they make sense of psychosis within the narratives of faith, on the other hand, they also present significant challenges to contemporary Christians who wish to reconcile those narratives with modern scientific understandings.

One such challenge that these narratives present is that of the relationship between spiritual intervention – demonic and divine – in a world order now understood primarily, in a secular order, through the lens of science. However, this is not the only difficulty. Nebuchadnezzar and the man from Gerasa were both excluded from their society, just as many people with major mental illness are excluded from society today. The cultural context of Nebuchadnezzar in the sixth century BCE, or the man from Gerasa in the first century CE, is very different than ours. The stigma associated with mental illness today (at least in many countries worldwide, but not all) cuts to the heart of personal identity in a more pervasive and damaging way than did models of divine judgement or demonic affliction then.

## Hearing God

Is hearing the voice of God a symptom of psychosis, a psychosis-like symptom, or a symptom of good spiritual health?

As indicated above, there have been attempts to argue that auditory verbal hallucinations, such as hearing the voice of God, provide evidence of psychotic disorder. In certain circumstances, it may indeed still be the case that such a voice may be a part of the overall presentation of psychosis [29]. However, it is no longer tenable (if it ever was) to suggest that this alone would be sufficient to make a diagnosis. Not only do we have ample evidence of non-pathological voice hearing in the normal population, but an increasing amount of research shows that – in certain circumstances – mentally healthy Christians can and do report hearing God speak to them in the context of prayer.

Tanya Luhrmann [30] has proposed an "attentional learning theory" by which Christians within certain evangelical traditions learn to pay more attention to their inner senses during prayer. The effect of repeated prayer practice of this kind, within a Christian tradition that both encourages and expects experiences of hearing God in prayer, is such that "sensory overrides" take place. In a sensory override, phenomena are perceived differently; for example, a voice is heard and experienced as though God were actually talking back. Such experiences are typically infrequent. They are not distressing and they may or may not take the form of an audible voice. The "voice of God" is often experienced more as though "God put a thought into my mind" [31]. Experiences of this kind appear to be more frequent in those who show a proclivity to mental "absorption" in inner experiences [32].

Experiences of hearing God are not confined to moments of intense absorption in prayer. Recent research suggests that they may occur at times of crisis, in the context of distressing circumstances, or at moments of religious conversion [33]. They may be significant in terms of forming a sense of vocational calling, for example, to ordained ministry. Whereas for most people they appear to be relatively infrequent, for some they may be ongoing and conversational. In such cases, God is a familiar friend, with whom daily (or at least frequent) conversation may take place.

Experiences of hearing the voice of God raise important questions for diagnosis and discernment. For mental health professionals, the clear message is that hearing the voice of God is not necessarily – or even usually – pathognomonic of a psychotic disorder. For clergy, counsellors, and spiritual directors, questions arise as to whether and how Christians might distinguish between spiritually authentic and inauthentic voices. The range of Christian tradition in this regard is very broad, from some who would urge caution to the extent of never paying attention to such phenomena through to those who would be broadly receptive. However, even in the latter case, various criteria for discernment are usually applied, and it is not assumed that such voices should be accepted uncritically [33]. For example, it is often suggested that talking and praying with other Christians is important, to see what they think, or that there should be examination of whether what the voice says is in accordance with the teaching of scripture.

## Demonic Possession

Belief in the activity of evil spirits, or demons, as causes of affliction of human well-being, is older than Christianity and is not unique to the Judeo-Christian tradition. Christian beliefs of this kind have their early origins in Hebrew scripture and tradition [34]. In the New Testament, Jesus is Himself tempted by Satan in the wilderness and during the course of His Galilean ministry casts out evil spirits from those who are afflicted by them. There has long been debate as to how such texts should be interpreted today, with some Christians taking a more literal view and others seeing them as open to reinterpretation in the light of medical and scientific advances in understanding. Correspondingly, there are different contemporary church practices in evidence, with some seeing exorcism, or deliverance ministry, as being a part of the mission of the Church today and others reserving only a very small place for such practices, if any at all.

Possession states are characterised by a belief that a person is under the control, or influence, of evil spiritual entities. Such beliefs may or may not be accompanied by other psychosis-like symptoms, and they may or may not be delusional. They are easily misinterpreted by psychiatrists who are not sensitive to faith/cultural context as evidence of psychosis when they are not. Belief in demonic possession is widespread in many cultures and is not uncommon in certain Christian

traditions even within Western culture [35]. As with experiences of hearing the voice of God, this situation presents challenges for diagnosis and discernment. In one of the earliest studies of possession, Oesterreich [36] distinguished between "true" possession and cases attributable to mental disorder (including psychosis). Reference to "true" possession does not necessarily entail belief in the reality of demonic entities, but it does recognise that such beliefs are culturally sanctioned and not unusual in many countries and communities worldwide. The question of diagnosis therefore relies heavily upon understanding the views and beliefs of the family and religious community, on the one hand, and the search for any evidence of mental disorder in the psychiatric history and mental state examination on the other hand.

Exorcism is the traditional Christian practice of expelling a demon from a person believed to be possessed. Different Christian churches each have their own, written or unwritten, liturgies and rules governing how such rituals should be practised. In at least some cases, it would appear that such practices are deleterious to the mental health of the person from whom the demons are said to be exorcised, and most mainstream churches now recognise the need for a multi-professional approach, with clergy and mental health professionals working together. Deliverance ministry is variously understood alongside exorcism as another means of responding to the plight of a person afflicted (but perhaps not possessed) by demons. Usually, deliverance is understood as something broader, or less invasive, than exorcism. However, it is not clear that it is necessarily any less harmful when inappropriately applied, especially in circumstances where the person concerned has an underlying mental illness. In some cases, there is clear evidence that people subjected to exorcism have found the experience deeply traumatic. Exorcism has periodically captured wider public attention, for example, following screening of the movie "The Exorcist" in the 1970s, sometimes causing fear and anxiety. In some Christian groups (notably in charismatic or Pentecostal churches), deliverance ministry or exorcism has been more highly prioritised than in others. Where such interventions are unsupervised, coercive, or not conducted in concert with advice from mental health professionals, there is a strong reason for concern that they may cause harm to the mental health of those subjected to them.

Given the worldwide frequency of occurrence of the phenomena, and the potential for harm when it is mismanaged, it is surprising that there has been very little systematic medical research on possession syndromes, deliverance, and exorcism. In one early study [37] of 66 admissions for possession syndrome (only 6 of which were Christians) to an inpatient unit in Hong Kong, only 20 were diagnosed with functional psychoses (16 with schizophrenia and 4 with mania). All were given standard treatments at the time, which did not then include neuroleptic medication. Of the total cohort, 59 were discharged in complete remission, but 5 of the 7 discharged in only partial remission had been diagnosed as suffering from schizophrenia. At follow-up 2 to 5 years later, six out of the eight who remained unwell also had a diagnosis of schizophrenia.

There is a view, amongst some Christians, that schizophrenia is caused by demonic activity [38]. The corresponding assertions that exorcism, or deliverance,

is effective in treatment of schizophrenia are based upon anecdotal evidence, usually (although not always) from non-medical sources. There is reason to be concerned that such practices may sometimes be very harmful, particularly where they are employed to the exclusion of medical care [33].

## Healing

It is interesting to note that, although there are many published accounts of Christian healing from a wide variety of medical conditions, Christian accounts of the healing of psychosis appear to be relatively few. Of course, it depends upon what one means by "healing". There is evidence that standard contemporary medical treatments for psychosis, for all their failings, actually do significantly improve outcomes and that the overall outcomes (with or without treatment) are not as poor as is sometimes alleged [39, 40]. These successes are healings of an important kind – albeit not distinctively or uniquely "Christian". There is also evidence that faith is a significant positive coping resource for Christians (and others) suffering from psychosis, although the so-called "negative" religious coping can make things worse rather than better [41–43]. Prayer contributes to healing (in psychosis and in other conditions), Luhrmann writes, through developing a relationship with a loving God in which the capacity to "make what is imagined more real and more good" is positively cultivated [43].

The Christian accounts of healing from psychosis that are available take very different forms and further challenge any simplistic or narrow account of what may constitute "healing" in this context. Three examples are illustrative.

Jo Barber [44], writing of her experiences of 30 years of living as a Christian with psychosis, has found healing in unexpected ways. Sadly, her story begins with an example of how churches, and other Christians, can make things worse. Hearing the voice of the devil, she sought help from a priest who then subjected her to a series of exorcisms which were at best ineffective and at worse highly distressing. Jo stopped going to church. Five years of hospital treatment was also initially unhelpful, but eventually a new psychiatrist recognised the importance of spirituality, in the broadest sense, and encouraged her to take up playing the violin again – something that she loved doing and had abandoned due to her illness. As he got to know her better, he also referred her to a chaplain who helped her to review her Christian journey and better understand the relationship between psychosis and faith. Eventually she was able to resume attendance at a different church, and she found a church community which was accepting and affirming of her. Jo has never been able to resume her work as a doctor, but through a long, and at times painful, struggle with her illness, she has eventually found a place of spiritual well-being and a sense of divine purpose in life. She is actively involved in research as a service user in the same NHS in which she has received treatment.

James Stacey [45] has a different story to tell, the initial signs of his illness appearing in the early/mid-1960s. Like Jo, the early emergence of psychosis was

intertwined with experiences of a growing Christian faith, in this case waking people at midnight so that he could get the chapel key and go there to pray. James also experienced many years of treatment from mental health services, having been diagnosed as suffering from schizophrenia, and his condition initially had a serious impact upon his work although, unlike Jo, he was able to continue working for many years in the post office. After 26 years of living with this illness, James became convinced that it was due to demonic influence. Prayer, for James, seems to have been of the "conversational" variety (see above), and the story of his restoration is intimately bound up with this. Having read a book about how schizophrenia can be caused by demons, James relates that he prayed "Lord, you'll have to help me because getting demons out is all new to me". "Blast them out" was what he experienced as God's reply (p. 85). Having experienced pain in his right knee, he discerned that this was the location of the demons in his body, and so he directed Christian music from a cassette player, as loudly as possible, into his knee. Commanding the "demon of schizophrenia" to leave, he experienced three "movements" in his leg, which he believes represented the exorcism of the demons of schizophrenia. At the end of his published account of his experiences, James is happily married, off medication, in good mental health, and actively involved in trying to help others who have had a diagnosis of schizophrenia. Whilst I have had to considerably abbreviate the account of James' restoration here, reading the book as a whole, it might be said that the story is much more one of recovery through prayer rather than exorcism, but the episode related here was clearly a significant turning point in the pathway to healing as James understood it.

Sharon Hastings [46] had a long struggle as a Christian suffering from complex and severe mental illness, her illness beginning before she gained her medical degree in 2007. Experiencing, at different times, depression, elation of mood (mania), paranoid delusions (a conspiracy involving her psychiatrist, messages that she thought were travelling through the "fourth dimension", and a belief that God was torturing her), and visual and auditory hallucinations (of tormentors/pterodactyls), she was diagnosed eventually as suffering from schizo-affective disorder. Sharon quotes the initial verses of Psalm 13 as capturing the essence of her struggle with mental illness and draws the title of her book, *Wrestling with My Thoughts*, from this source. Later in the Psalm (verses 5–6), as Sharon notes, the psalmist remembers God's goodness even amidst all the wrestling. She gives 12 examples of God's goodness amidst her own struggles, including the skilled and caring psychiatrists who looked after her when she attempted suicide, her loving husband, and a supportive church community. Sharon found solace and a new vocation in writing. Sharon's experience of healing is not an easy one; her story is one of ongoing wrestling, not only with her thoughts but with God, with her vocation, with relationships, and with hope.

These three stories all recount Christian attempts to come to terms with a life-changing and debilitating condition. A psychiatrist may well point out that the course of James' illness (whilst still very serious) appears to have been somewhat less severe than that experienced by Jo or Sharon and that this was why he was able to continue working for much of the time. Stories of the supposed cure of

schizophrenia by exorcism are relatively rare, and even in James' case, this took 26 years to come about. Good outcomes in the longer term are sometimes observed without such interventions, and we cannot know whether James might still have recovered without this. However, in different ways, Jo, James, and Sharon all found their Christian faith to be a vital coping resource during their illnesses. Their Christian faith has also been important in helping them to find new vocations in recovery.

It is not generally clear in these three examples whether the treating psychiatrists were Christians, or people of other faiths, or people of no faith. It is clear (e.g. in Jo's case) that some were more sensitive to the importance of spirituality/religion than others. Whilst many Christians say that they would like to see a Christian psychiatrist, psychiatry can bring about its healing through the hands and minds of doctors, nurses, and other professionals of all faiths and none. What is important is that they are supportive of the faith of their Christian (and other) patients, recognising the power for healing that this faith brings, and that they do not stand in its way.

At the end of a book drawing on a series of in-depth conversations with Christians who have lived with schizophrenia, bipolar disorder, and depression, John Swinton [47] argues that we need to rethink or "re-describe" healing in relation to mental health. He suggests, in this context, that there are seven dimensions of healing: cultural, liturgical, biblical, theological, epistemic, testimonial, and relational. All of these are in evidence in the stories of healing that I have briefly summarised here (and all the more evident in the full accounts as originally published by Jo, James, and Sharon themselves). Churches, potentially, provide the places within which Christians can find healing from psychosis, but in practice, some church cultures can be pathogenic rather than restorative. Similarly, liturgy, scripture, and theology, wrongly used, can cause harm rather than good. Healing comes through listening well to the experiences of those who struggle with psychosis and in human kindness. As Swinton says in the concluding sentence of his book, "It's not really that complicated".

## Care in Churches

Whilst healing from psychosis may not be complicated, that is not to say that it is easy.

In a study [48] of 115 outpatients with psychotic illness in Geneva, 61% of whom were Christians, 71% ($n = 82$) used religion as a positive form of coping with their illness. Within this group, religion was generally reported as important, providing comfort, meaning, hope, and a positive sense of self. Despite this, only one third ($n = 27$) found support in their religious communities. One 31-year-old man with schizophrenia told the researchers:

> I am angry with my brothers in Christ because they did not help me at all. Religious teaching helps me, but I haven't found any warmth in relationships with people. On the contrary, I feel persecuted by them. (p. 1955)

Stigma has been referred to as a "spoiled identity" [49]. The identity of many people with psychosis has been spoiled, both within Christian churches and in wider society. They are not valued or respected as equal members of society. Even if they do not feel actively persecuted (and such feelings need not be delusional), then they may still feel excluded. According to the gospels, Jesus of Nazareth was known for including such people; He associated with those who were on the margins of His society. People suffering from psychosis are on the margins of our societies (although exactly how this works out varies in different cultures around the world), and it is a central Christian calling to respond to their needs for inclusion, affirmation, and care.

If responding to the challenges of stigma requires us to restore the identity of people with psychosis, then inclusion also requires that churches should be welcoming. To be a welcoming community, it has been suggested, depends upon two principles: compassion and dignity [50]. However, these principles are potentially in conflict. Christian (and other) educational initiatives in mental health have often focussed on compassion, but too much emphasis on showing compassion and mercy may undermine dignity and reinforce powerlessness and hopelessness. The difficult balance between these principles requires a valuing of difference and of the experiences of people with psychosis and of the positive contribution that they may make within the life of the church.

For those who do find warmth within their churches, the social support that they gain is perhaps one of the most important benefits, and this is expressed in many small and significant ways. Prayer is appreciated, but also gestures of practical help and expressions of concern. Invitations for coffee or a meal, inclusion in the coffee or flower rota, and being asked to help with the food bank all provide opportunities for belonging and feeling valued.

Liturgy, in the sense of the entirety of practice of an assembled congregation, including all its symbols and rituals (not just those that are printed or written), is an important means of including (or excluding) people with psychosis. Often, people with physical, medical or surgical, illnesses are prayed for in church, but not those with mental health problems. Similarly, people with psychosis are often not invited to lead prayers in church. Whilst this may not be entirely appropriate during acute episodes of illness, failure to be involved at other times creates a powerful message of exclusion – of not fully belonging.

If practical, ritual, and symbolic aspects of the liturgy are important, this is not to downplay the importance of words. In many churches, it is rare to hear a sermon preached on mental health – let alone on psychosis. At the same time, preaching on topics such as demonic possession (in some traditions) may – if not handled sensitively – make things worse for a member of the congregation struggling with demonic voices. The relationship between the demonic and mental health is complex and does not lend itself to simplistic teachings that appear to reduce complex problems of body, mind, and spirit entirely to the activities of literally understood

demonic entities. Churches easily give confusing and conflicting messages which do not tally with what patients hear from mental health professionals. One patient, quoted by Mohr and Huguelet, said:

> I don't know why I suffer from deep anxiety and hallucinations, the psychiatrist told me it was nerves, and the pastor and the members of my church pray for me to be delivered from bad things in the name of Jesus … it is God who gives wisdom to psychiatrists for medication, I pray for caregivers, I put my hope in God and I take my medication [51].

Not all such patients continue to take their medication, and there is a need for churches to affirm the positive place for medical care.

Churches also need to approach scripture with care, both in the context of the liturgy and also in home study groups and Christian education more widely. People with mental health problems may read scripture differently, and space needs to be created for their voices to be heard. John Swinton [52] has argued that there is a need for a "mental health hermeneutic" that takes seriously the experiences of people struggling with mental health problems. Such a hermeneutic should be critical of misrepresentations of mental health issues, prophetic in challenging cultural assumptions in the light of the gospel, and faithful to the Christian revelation as received in scripture. For example, based upon the practice of lectio divina, one church has developed an initiative of "Dwelling in the Word", as a way of ensuring that all voices are heard in Bible study together and that the experiences of those with mental health problems are valued [53]. In these groups, listening is valued, and the contributions of all (including those with mental health problems) are received. Again, such groups are certainly not the place for someone in the midst of an acute psychotic episode, but this does not mean that people struggling with psychosis over the longer term cannot be included.

## Care in Mental Health Services

Care of people with psychosis in hospital, and in community mental health services, has often not taken faith as seriously as it should have done. Religion provides a positive coping resource for many people with psychosis, including Christians [54]. Conversely, in one study, perceived incompatibilities between faith and medication account for one third of cases of non-adherence to treatment [55]. It is increasingly clear that assessment of spirituality/religion in psychiatry is important in general [56] and psychosis is no exception.

In one-to-one care of a Christian patient, there is opportunity to discuss faith in specific terms, to allay any concerns about perceived conflicts between faith and treatment, and to consider ways in which faith may be mobilised as an effective coping resource. There is reason to believe that patients with schizophrenia draw less on collective religious practices and more on individual practices. Care can therefore usefully focus on identifying which religious coping resources a patient is employing, encouraging and supporting those that are positive, and identifying and working on those that may be negative. Other areas of clinical work that may be

important include working on identity and values, differentiating delusion from faith, and exploring the relationships between illness and faith more widely [54]. Referral to a mental health chaplain may also be helpful.

In some facilities, group work is used to address the spiritual/religious needs of patients with psychosis [57]. Whilst this has certain advantages, it will also usually (but not necessarily always) mean that faith is addressed within a more pluralistic context. Such groups may operate in a variety of different ways, but topics addressed include such things as spiritual/religious coping, forgiveness, spiritual struggles, loving kindness meditation, the overlap between psychotic symptoms and spirituality, and spirituality in recovery [57].

## Conclusions

Christian scripture and tradition are rich with accounts of human encounters with a spiritual world within which God, angels, and demons are said to communicate with and engage with human beings. In this context, there will always be scope for ambiguity in the interpretation of scripture in the light of experience and of experience in the light of scripture. Hearing the voice of God, or believing oneself to be possessed by demons, may be understood within the context of a continuum of psychotic-like experiences in the population. Reading such an understanding back into history, Abraham will then be seen as deluded and Ezekiel as suffering from symptoms of schizophrenia. On the other hand, perhaps there is more discontinuity? Certainly, this is what most Christians have always affirmed. There is a need to discern whether God was speaking and what God is saying. Was the voice that was heard truly divine, or demonic, or just a symptom of psychosis? How that question is answered carries huge implications for clinical and pastoral care.

Christians and clinicians alike have long agreed that some people who report apparently spiritual phenomena are actually experiencing symptoms of psychosis. The pathway to healing for such people is often not an easy one, and recovery may take many years, but there is reason to believe that prayer may play an important and beneficial role within it. To care well for such people, within the church or the clinic, requires much better mutual understanding and collaboration between clergy and clinicians than has often been evident in clinical and pastoral practice in the past.

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# Chapter 4
# Mood Disorders and Christianity


**Jennifer Huang Harris**

The following case study illustrates the complex relationship between Christianity and mood disorders:

*Stephanie had had a difficult and chaotic childhood, with abusive and alcoholic parents. She had found meaning in her Christian faith, which offered love and acceptance which she had never felt from her parents. She married a pastor, and they loved discussing their dreams about how to care for people in their community. However, after the birth of her third child, she started experiencing periods of depression and loneliness, as her husband was often busy with his ministry. She felt often as if she were parenting alone. There were times when she was walking close to God, and she would feel filled with the Spirit and full of purpose, and she would pour herself out into service in the church. But more often there were times when God felt distant, when she had difficulty feeling God's love no matter how much she prayed and studied Scripture. During one particular dark time, she and her husband were fighting, their church was being torn apart by internal conflict, her children were misbehaving, and she felt like everything was falling apart. She found herself drinking to calm her nerves, and suicidal thoughts began crossing her mind with alarming frequency. She was horrified that she could be thinking of such a sinful act against God. She had sought out multiple Christian counselors over the years, but none of them seemed to really help. Despite her misgivings, she finally sought the help of a psychiatrist. She was taken aback when he diagnosed her with bipolar disorder. Her abusive, angry, alcoholic father had bipolar disorder. She had marital struggles and the challenges of being in ministry with young children. But bipolar disorder? What did that mean? Did this mean that the ups and downs*

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*of her emotions and the ebbs and flows of her spiritual life were merely manifestations of a psychiatric disorder?*

## Introduction

The mood disorders (or affective disorders) are characterized by extremes in emotional states and encompass conditions such as dysthymia, major depressive disorder, and bipolar disorder. The fifth edition of the *Diagnostic and Statistical Manual* (DSM-5) considers depression to be primarily characterized by anhedonia or loss of pleasure [1]. Bipolar disorder is characterized by periods of heightened energy and motivation, followed by a drop in energy and motivation during the low periods of depression. The core feature of these diagnoses is a change in pleasure and motivation. But an alternate way to conceptualize mood disorders could be as a loss or surfeit of hope and meaning. As Victor Frankl, the Jewish psychiatrist and Nazi concentration camp survivor, observed, "Life is not primarily a quest for pleasure, as Freud believed, or a quest for power, as Alfred Adler taught, but a quest for meaning. The greatest task for any person is to find meaning in his or her life" [2]. Traditional psychiatric thinking about mood disorders is still heavily influenced by psychoanalytic theory, which considers the emotions to be a product of hedonistic drives. Frankl suggests a different motivational theory, in which people are motivated by meaning. While Frankl's solution to a loss of meaning was to create existential meaning in therapy, he was aware that traditionally, religion and spirituality fulfilled this role. Frankl wrote, "Life is a task. The religious man differs from the apparently irreligious man only by experiencing his existence not simply as a task, but as a mission. That means that he is also aware of the taskmaster, the source of his mission. For thousands of years that source was called God" [3].

As the predominant religion in the United States [4] and historically in much of the Western world, Christianity carries important implications for mood disorders. Christianity is distinctive for its emphasis on sin and grace and the relational dimension of alienation from and reconciliation with God [5]. How do we reconcile a spiritual quest for meaning-making with the medical conceptualization of mood disorders? Are these two approaches diametrically opposed? What implications does a Christian viewpoint have for the presentation and treatment of mood disorders?

In this chapter, we explore the complex relationship between Christianity and mood disorders, namely, major depressive disorder and bipolar disorder. We will review whether Christian belief seems to protect, exacerbate, or improve mood disorders. We will also examine the role of guilt and religious experience and how these may complicate the presentations of mood disorders. We discuss the Catholic traditions of acedia and dark night of the soul and how these might help distinguish between spiritual states and psychopathology. Lastly, we discuss the importance of Christianity in coping with mood disorders themselves.

## Christianity and Mood Disorder Outcomes

Currently, most of the research on religion, spirituality, and health has taken place in North America, particularly in the Southeastern United States where Christianity is the predominant religious affiliation [6]. The research suggests overall that there is a moderate inverse relationship between measures of religiosity and depression. In a systematic review of 444 studies examining the relationship between religion, spirituality, and depression, Koenig et al. found that 272 (61%) reported significant inverse relationships with depression, while a much smaller percentage, i.e., 28 studies (6%), found greater levels of depression. Of the 178 studies with the highest methodological rigor, 119 (67%) reported inverse relationships and 13 (7%) found positive relationships with depression. Of 70 prospective cohort studies, 39 (56%) reported greater religion and spirituality predicted lower levels of depression or faster remission of depression, 7 (10%) predicted worse future depression, and 7 (10%) reported mixed results [7]. In addition, several research studies have suggested that religiosity is associated with a shorter duration of depression [8].

The relationship between Christianity and bipolar disorder is less clear, limited by the smaller number of studies available. Of the four studies reviewed by Koenig, two found a positive association between bipolar disorder and religiosity, and the other two found both positive and negative correlations [7]. Another study by Baetz et al. of 37,000 Canadians found that those who attributed greater importance to higher spiritual values were more likely to have depression or bipolar disorder, although a higher frequency of attendance of religious services was associated with a lower risk of depressive and bipolar disorders [9]. The cross-sectional nature of this study, however, makes it difficult to determine causality (see below).

Religious belief and practice are thought to be protective for mood disorders via several pathways. From a social support perspective, belonging to a Christian community decreases the social isolation which is a major risk factor for mental illness. Being part of a community also helps individuals cope with adversity, as increasing altruistic and pro-social activity decreases the inward focus so common to depression [7]. From a cognitive perspective, Christianity can promote positive beliefs that reinforce a positive worldview (e.g., emphasis on the value of every human being and the belief that God works all things for good), increase an internal locus of control [10], and increase positive self-regard [7]. From an existential perspective, Christianity can help individuals make sense of aversive life circumstances and give a sense of purpose, meaning, and hope [11].

Furthermore, there is strong evidence that Christianity is protective when it comes to suicidality [12]. Studies consistently find that religious involvement is associated with lower rates of suicide, thought in part due to an emphasis on the value of human life and prohibitions against suicide as a mortal sin. Among these studies, one of the most robust is a longitudinal cohort study of 89,708 female nurses, which found that women who attended religious services once per week or more had an approximately fivefold lower rate of suicide compared to non-attendees [7, 13, 14]. Christianity emphasizes God's sovereignty over individual lives and that God's purposes are for good (Romans 8:28). Christianity also states that suffering

does not diminish the worth of a human life but that there is intrinsic dignity and worth to each human life as a reflection of the image of God [15].

However, the relationship between Christianity and mood disorders is also bidirectional. Mood disorders can affect engagement in religious practices. Some have critiqued the research finding that religious service attendance decreases depression, stating that the direction of causality may be incorrect. Those with depression often exhibit social withdrawal and amotivation, which could help prevent church attendance. A research study by Maselko et al. examining religious service attendance and depression found that women who were raised attending church and experienced the early onset of depressive episodes stopped attending church services [16]. This might be due to negative social interactions with their church community, perceived negative interactions due to the cognitive distortions of depression, or decreased energy and motivation. On the other hand, the presence of mood symptoms could increase use of religious coping, which would appear as a positive correlation between religious practices and emotional distress [16]. Greater religiosity could either reflect increased religious coping as a response to distress or be a sign of the severity of the mood episode, particularly if it tips into psychosis [17].

Religiosity may also serve to exacerbate mood disorders. We discuss elsewhere in this book how mental illness stigma in Christian communities can contribute to [1] underreporting mental illness due to defining their problem as a spiritual problem and [2] interfering with accessing and adhering to mental health treatment [18, 19]. Conflicts over church dogma and difficulty reconciling the experience of depression with doctrine can also contribute to negative emotion [20].

Christianity is a very relational religious tradition, in its emphasis on relationships with God and other members of one's Christian community. When asked to summarize the greatest commandment, Jesus responded, "'Love the Lord your God with all your heart and with all your soul and with all your mind.' This is the first and greatest commandment. And the second is like it: 'Love your neighbor as yourself.' All the Law and the Prophets hang on these two commandments" (Matthew 22:36-40, ESV). Relational involvement often brings comfort and other benefits, but these relationships can also produce conflict. When these interpersonal conflicts occur in a person's Christian community, they can trigger depression and feelings of alienation from others, and the resulting religious strain is highly correlated with depression and suicidality [5]. Alienation from God is a major predictor of depression [5], and inability to resolve anger at God has been linked with negative emotions [20]. Exline et al. found that suicidality was associated with sin and guilt, in particular the belief that one had committed a sin that was too big for God to forgive [5].

## Presentation: Differentiating Between Psychopathology and Spiritual States

An important task when treating a person with religious beliefs is to differentiate psychopathology from healthy religious coping. In what ways do spiritual and clinical depression overlap? Is it possible to have a spiritual depression without clinical depression or vice versa? This task presents a problem for many mental health

professionals who are uneasy with the topic of spirituality and may simply interpret religiosity/spirituality as a symptom of psychopathology [5, 12]. Is the patient's religiosity and spirituality contributing to psychopathology, a symptom of their disease, or could it play a positive role in recovery?

## *Effect of Depression on Spiritual Life*

Depression produces negative cognitive distortions which have the power to color a person's view of self, others, and the world [5]. Severe depression is often experienced as an existential crisis that erodes meaning and hope, thereby having a significant impact on one's spiritual life as well [21]. Those who are depressed often have lost hope and meaning that used to give direction and purpose to their lives. As pastor and author Zack Eswine put it, "imagine how this rupture of meaning feels to sufferers of depression, when 'the world in our heads' is filled not with 'reasons, plans, love and purpose' but with the loss of reasons, plans, love and purpose. In this state, both the world out there and the one within conspire miserably to deny hope. Both the floor and ceiling vanish. We free-fall with no place to land. When realistic hope quits, so do we" [22].

A common perception in many Christian communities is that depression is spiritual in nature – evidence of sin, a sign of demonic activity, or simply distance from God [23]. It is possible that some cases of depression may be caused primarily by spiritual issues, as noted above. There may be unresolved issues between a person and God, or depression may be due to sin. If a person has committed immoral acts, the burden of guilt or the consequences of their action may cause mental distress. Accurately or not, Christians often see the guilt that accompanies depression as indicating the presence of sin in a person's life.

However, inappropriate and excessive guilt itself can be a cognitive distortion, i.e., personalization produced by depression. Many depressed people blame themselves for situations beyond their control, even to the extent that they may become delusional. Clinical depression can cause a person to doubt that they can be saved or to believe that they have committed sins that cannot be forgiven. The depressed person may not know whether he or she is experiencing guilt due to sin or whether guilt is exaggerated or delusional and due to depression. If exposed to a church environment that emphasizes that depression is solely a spiritual disorder, those with clinical depression may easily come to believe that their suffering is a result of sin [24].

When it comes to considering the contribution of a person's spiritual life to their depression, two useful models to consider from the Catholic tradition are acedia and "dark night of the soul."

## *Acedia: Depressive Symptoms and Spiritual Apathy*

Acedia serves as an example of depressive symptoms thought to be secondary to spiritual apathy. In the fifth century AD, Evagrius of Pontus first described the eight capital sins, which included (1) pride, (2) vanity, (3) acedia, (4) depression, (5)

anger, (6) avarice, (7) fornication, and (8) gluttony. His disciple John Cassian described acedia as "disgust or boredom, which can be otherwise called inquietude or perturbation of the heart or anxiety" [25]. Notably, acedia was considered to be distinct from the concept of depression or sorrow. The term acedia originally described a rite of passage for monks adjusting to the solitary ascetic life, in which they would struggle with the repetition and isolation of their work and be tempted to leave their profession. Over time the definition of acedia evolved. Pope Gregory I combined acedia with sorrow in his list of the seven deadly sins. Thomas Aquinas applied the term acedia to the layperson, and not only to monks, and considered it to be a spiritual phenomenon of "aversion of the appetite from its own good… and an aversion against God himself" [26, 27].

In modern usage, the term acedia has come to be used interchangeably with depression, ennui, or boredom. Roman Catholic priest Richard John Neuhaus applied the term to describe the purposelessness and listlessness that people fill with mindless entertainment. He stated, "Acedia is evenings without number obliterated by television, evenings neither of entertainment nor of education but of narcotized defense against time and duty. Above all, acedia is apathy…" [28]. Theologian Kevin DeYoung elaborated in his book *Crazy Busy*, "We are busy with busyness. Rather than figure out what to do with our spare minutes and hours, we are content to swim in the shallows and pass our time with passing the time. How many of us, growing too accustomed to the acedia of our age, feel this strange mix of busyness and lifelessness? We are always engaged with our thumbs, but rarely engaged with our thoughts. We keep downloading information, but rarely get down into the depths of our hearts. That's acedia—purposelessness disguised as constant commotion" [28].

Theologians propose that depression and acedia share common features, such as anhedonia, amotivation, low mood, irritability, and social withdrawal [26]. However, they state that acedia is characterized by indifference and a sense of agency, compared to the anguish and helplessness of depression [24, 25]. The writer Kathleen Norris, in her book *Acedia and Me*, has suggested that depression generally has an identifiable and external cause that acedia lacks and that depression tends to be disruptive and hard to ignore, whereas acedia is more insidious [27]. Those with acedia are able to make use of spiritual resources, whereas those suffering from depression have difficulty engaging spiritual resources due to the impairment in cognition and functioning caused by depression [26]. The Catholic tradition held a person responsible for the rectification of acedia. To remedy acedia, Evagrius suggested "endurance cures listlessness, and so does everything done with much care and fear of God." For this type of depression arising from spiritual apathy, spiritual resources were considered adequate. Christians were also encouraged to examine their consciences and engage in confession, prayer, and other devotional exercises [26]. It is possible that a condition such as acedia might be diagnosed as mild depression, and in such a condition, spiritually oriented therapy might be more appropriate than psychopharmacologic intervention.

## *"Dark Night of the Soul": Depressive Symptoms and Spiritual Growth*

Alternatively, some Christian traditions have considered certain forms of depression such as the "dark night of the soul" to be characteristic of a stage of spiritual growth [23]. In the 1570s, the Roman Catholic mystic St. John of the Cross wrote the poem "Dark Night of the Soul," in which he describes the painful experience and state of darkness required to attain spiritual maturity and union with God. Since that time, the term "dark night of the soul" has become an expression used to describe painful phases in a person's spiritual life associated with a crisis of faith or concerns about one's relationship with God that represent a healthy and important stage of spiritual growth [29, 30]. Depression of this type is an expression of the pain provoked by the search for God [27]. This "Dark Night of the Soul" is best exemplified in Jesus' agony during His passion, when He felt abandoned by God. He is described at the Garden of Gethsemane as being sorrowful almost to the point of death and was in such agony that He sweated drops of blood (Matthew 26:38, Luke 22:44). His agony reached an apex at His death on the cross, when darkness covered the land, as Jesus cried out, "My God, my God, why have you forsaken me?" (Mark 15:34). Mother Teresa was also thought to have experienced this "dark night of the soul." In a published collection of her personal letters, she describes a four-decade-long period of spiritual darkness and doubt, in which she struggled with "that terrible pain of loss, of God not wanting me – of God not being God – of God not existing" [31]. Nevertheless, despite these doubts, she continued her steadfast service to the poor and saw in the outcasts and the dying a reflection of her own internal pain [29].

As with acedia, many symptoms of clinical depression and the "dark night of the soul" overlap. Low mood, amotivation, and anhedonia characterize all three. However, where acedia is characterized by indifference, the "dark night of the soul" is also characterized by spiritual agony – negative self-evaluation and guilt, the painful perception of the absence of God – as well as somatic symptoms such as insomnia or hypersomnia, fatigue, and loss of appetite [32]. In the "dark night of the soul," prayer can feel difficult, and God can feel absent, replaced instead by an experience of emptiness.

Theologians have proposed key differences between clinical depression and the "dark night of the soul." Unlike one who suffers from clinical depression or acedia, a person experiencing the "dark night of the soul" does not withdraw from social interaction and continues to be involved in interpersonal relationships and service to others [29]. The individual experiencing the "dark night of the soul" continues to hope in God and takes courage in the belief that there is a purpose to the pain. In contrast, the depressed person is embittered and hopeless and wants immediate relief, even by means of suicide [27, 33].

However, it is also possible for a person to experience both a "dark night" and clinical depression, which are sometimes impossible to tease apart. The "dark night of the soul" can develop into clinical depression if there are underlying depressive

tendencies or if the intensity of the conflict overwhelms the fragility of the person's emotional state [29, 30].

The benefit of this view of depression is that it offers the possibility of finding spiritual meaning and significance in emotional distress [23]. Dura-Vila and Dein suggest that "once the feelings of sadness and dissatisfaction are defined in existential terms – as is the case for people undergoing the Dark Night – it can cease to be pathological and it may even be resolved through the attribution of meaning, allowing the individual to reflect on the negative aspects of their life. This can then become an adaptive reaction that instigates transformation of those aspects, thus making positive changes in one's life. … By giving a diagnosis of a depressive episode to the Dark Night of the Soul, psychiatrists may hold up – or even prevent – the attribution of meaning to take place." Rather than perceiving depression as an indication of distance and alienation from God, people can perceive their mental distress as a process which draws them closer to God.

However, the significant overlap between "dark night of the soul" and a more severe clinical depression makes it risky and potentially irresponsible to treat it only as a spiritual disorder. This interpretation risks romanticizing suffering and consequently may decrease the incentive to recover [23]. In such a case, it might be prudent to pursue a holistic approach that incorporates spiritual, psychologic, and pharmacologic means of treating the emotional distress.

## *Mania: Heightened Religious States Accompanying Psychopathology*

The manic episodes of bipolar disorder present particular challenges, as pathological symptoms can often be accompanied by religious experiences and a sense of spiritual insight. Identifying psychopathology while respecting religiosity is an important task in bipolar disorder [34]. We see this in the case study, as Stephanie struggled to reconcile her diagnosis of bipolar disorder with her spiritual history and wondered whether to reinterpret her spiritual highs and lows as symptoms of mental illness.

Increased religious experience is common among those with bipolar disorder. A study by Gallemore et al. of 62 individuals found a higher prevalence of conversion or salvation experiences among those with bipolar disorder (52%) compared to controls (20%) who had a similar religious background [35]. Similarly, a study by Kroll and Sheehan found that 55% of patients with bipolar disorder with manic episodes reported having religious experiences, compared with 35% of people in the general population. One study of 334 US veterans by Cruz et al. found that a higher frequency of prayer and meditation was associated with mixed states and lower rates of prayer with euthymic states [36]. Again, however, given the cross-sectional nature of this study, causality cannot be concluded. (For example, prayer may have been a response to the distress experienced during mixed states.)

Those with bipolar disorder often experience conflict between spiritual and medical interpretations of their condition. Conflicting explanatory models have been shown to hinder treatment [37]. Mitchell and Romans' cross-sectional study of 81 individuals with bipolar disorder found that the majority (94%) reported holding a spiritual, religious, or philosophical understanding of the world. In that study, 24% of individuals reported conflict between the medical paradigm for their illness and their own spiritual beliefs, and 19% reported conflict between their medical and spiritual advisors. The spiritual versus medical paradigm seemed to be considered antithetical to each other, as greater strength of religious belief was associated with poorer medication compliance [34, 38]. Ouwehand et al.'s study of 196 bipolar patients in the Netherlands found that of the 66% who had religious experiences, 46% considered them to be part of their spiritual development, 42% considered them to be both spiritual and pathological, 31% reported distancing themselves from these experiences, and 15% considered them to be only pathological [29, 33].

The task of navigating between religiosity and psychopathology appears to be a priority for people suffering from bipolar disorder. Ouwehand et al. conducted a 2019 study involving qualitative interviews of 34 individuals with bipolar disorder. A search for meaning or religious quest was commonly reported by participants, particularly during manic episodes. A clear distinction could not be made between genuine religiosity and psychopathology. Most participants endorsed mixed religious and medical explanations for their bipolar disorder. Fewer participants used exclusively medical or exclusively spiritual explanations [37]. Many experienced a sense of meaningful coherence and significance and increased spiritual insight during their periods of mania. However, over time, most recognized the destruction that resulted from the manic episodes outweighed any spiritual gains they might have experienced during mania. In periods of depression, many felt closed off from the spiritual and retrospectively interpreted the religious experiences during mania to be pathological. These periods of depression were often experienced as a spiritual crisis, especially after the loss of the spiritual coherence and meaning that was experienced during mania.

Although the medical model generally considers the mood fluctuations of bipolar disorder to be primarily biological, there are some who speculate that bipolar depression may represent a more spiritual or existential despair over the failed hopes of mania [39]. This suggests an important role for therapy addressing the spiritual and existential crises occurring in bipolar disorder. Simply dismissing religiosity as a bipolar symptom fails to recognize the significance of meaning-making in treating bipolar depression.

During their mental illness, individuals often experience a process of trying to reevaluate and integrate both medical and spiritual views of their bipolar disorder and over time develop a more balanced view. Participants in the Ouwehand et al. study reported continued religious involvement even after recovery [37]. Other studies, however, have suggested that the religious interest in bipolar disorder is only transient in nature [34].

## Religious Coping with Mood Disorders

The Danish philosopher Soren Kierkegaard, who struggled with lifelong depression, suggested that it is possible to choose how one responds spiritually to one's emotional states and to maintain hope even in the face of mental distress. He considered a person who is depressed to be struggling with mental and emotional anguish, whereas a person who is in despair has given up all hope. According to Kierkegaard, as long as one chooses to maintain hope, one can be spiritually healthy despite being afflicted with depression [40, 41].

We also see this viewpoint operating in Psalm 42, when the Psalmist describes and then responds to his depression:

> My tears have been my food day and night…
> My bones suffer mortal agony as my foes taunt me,
> saying to me all day long,
> "Where is your God?" …
> Why, my soul, are you downcast?
> Why so disturbed within me?
> Put your hope in God,
> for I will yet praise him,
> my Savior and my God.

The depression mocks his faith and plants doubts in his head – "Where is your God?" But he answers this question with another question and then a statement of faith. "Why are you downcast? Put your hope in God, for I will yet praise him." The Psalmist does not merely acquiesce to the rising tide of depression but speaks against it, exhorting himself to maintain hope in God.

This confidence that one has the spiritual resources necessary to endure and draw redemptive meaning from adversity is the concept of *spiritual fortitude*. Whereas resilience or grit focuses on helping people push through suffering to get back to life, fortitude helps one to find life amid the suffering [42]. This is particularly relevant in chronic conditions such as bipolar disorder, which may never be completely "cured."

So far in this chapter, we have explored the ways in which religion and spirituality might be considered a *cause* for mood disorders and the ways in which religion and spirituality might be a *manifestation* of a mood disorder. Religion and spirituality also represent an important *coping strategy* utilized by people experiencing mood disorders. According to the psychological theory of coping, when a person is pushed beyond their capabilities, the coping process is triggered, which involves attempts to minimize the effect of the stress on the person [43]. A study by Russinova et al. suggested that roughly half of those with mood disorders turned to religious or spiritual activity to cope. In depression, 56–58% reported turning to religious or spiritual activity to cope, and in bipolar disorder, 41% relied on religious and spiritual activity to cope [44].

When faced with mood disorders, religion can be an important positive source of coping or, alternatively, may be a form of problematic coping [20, 45]. Studies have shown self-worship, religious apathy, anger at God, focus on God's punishment,

religious doubt, interpersonal religious conflict, and conflict with church dogma to be associated with poorer mental health. In other studies, higher depressive symptoms have also been associated with spiritual discontent, negative reframing, and self-directed (without God's help) religious coping styles [20, 46]. The lowest rate of depressive symptoms has been associated with positive religious coping strategies such as seeking spiritual support, expressing spiritual content, receiving congregational support, and benevolent reframing of the stressful event. Positive religious coping in Christianity often involves the perception of a close collaborative relationship with God, e.g., "in all things God works for the good of those who love him" (Romans 8:28, NIV) [47].

Hope and meaning-making are important in recovery from mental illness, and the patient's family and friends, mental health providers, and clergy can all play a vital role in this regard. In Ouwehand's qualitative study of bipolar patients, many participants expressed loneliness due to the inability to share their religious experiences with other people without facing judgment. It was painful when family and friends considered their religious experiences to be only pathological. It was more helpful when friends, family, and clergy offered non-judgmental and empathic listening and viewed the spiritual experiences as neither simply pathological nor revelatory.

With respect to mental health providers, half of the participants felt that their mental health providers were only interested in scientific explanations, not their spiritual experiences. The medical model for their experience was experienced as reductionistic. Participants suggested it would be helpful for mental health providers to investigate whether religiosity or spirituality was important to the patient and, if so, consider whether contact between mental health professionals and clergy or chaplaincy would be helpful. Participants valued interest shown by their mental health provider in their spiritual experiences and encouragement of their quests for meaning [37].

The ability to hold onto hope and find meaning is critical to enduring any kind of suffering, including the suffering caused by mood disorders. It may not always be clear whether a person's Christian faith has contributed to the development of a depressive episode or is a manifestation of psychopathology. However, just as a person's Christian faith may be an important source of strength for coping with cancer treatment, faith may be a vital resource with which to cope and recover from a mood disorder.

## Conclusion

Since the relationship between Christianity and mood disorders is complex, mental health clinicians and clergy working with people suffering from mood disorders are wise to note the interplay between spiritual states and psychopathology. Spirituality offers a perspective crucial for understanding depression and mania as disorders of meaning-making and hope. Research suggests that greater religious involvement is

associated with lower rates of depression, but negative aspects of religiosity and spirituality such as conflict with one's Christian community, or perceived alienation from God, can also exacerbate mood disorders. Distinguishing between "clinical" and "spiritual" depression is not always easy. Guilt may be evidence of sin or a symptom of depression. Perceived alienation from God may be a spiritual issue or a symptom of the negative cognitive bias present in depression. In mania, heightened religiosity may be a sign of severe mental illness or an attempt to cope with emotional highs and lows.

Nevertheless, the Christian faith is a significant resource for coping with mood disorders. By comparison with other traditions which may try to avoid or deny the reality of suffering, Christianity finds meaning in the anguish of depression and mania. Christianity suggests that suffering can be redemptive and lead to healing and growth. The central figure of the Christian faith is one who knew grief and sorrow, one who understands the suffering of his people (Hebrews 4). It is through the suffering of Christ that Christians find their reconciliation with God, and it is through the suffering of Christ that Christians find their peace and hope.

> He was despised and rejected by men,
> a man of sorrows and acquainted with grief;
> and as one from whom men hide their faces
> he was despised, and we esteemed him not.
> Surely he has borne our griefs
> and carried our sorrows;
> yet we esteemed him stricken,
> smitten by God, and afflicted.
> But he was pierced for our transgressions;
> he was crushed for our iniquities;
> upon him was the chastisement that brought us peace,
> and with his wounds we are healed.
> (Isaiah 53:3-5, NIV)

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## *Suggested Resources*

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# Chapter 5
# Working with Christian Children and Families


**Julie Mary Sadhu, Joshua Williams, and Mia Everett**

## Introduction

Various factors distinguish work with children and adolescents from that of adults. Children and adolescents lie along a developmental trajectory, mentally, physically, emotionally, and, oftentimes, spiritually. In addition, they operate within systems of family, peers, school, and self [1]. These systems exert a dynamic influence upon the development of children that affects the child's mental and emotional well-being. When children enter adolescence, they often engage in the processes of separation, individuation, and identity development, and, for some individuals, religious affiliation and spiritual practices and beliefs can greatly impact this process of identity formation. Within this context, the spiritual or religious background of the parents, the community at large, and the child or adolescent can play an important role in healthy development or in the development of pathology. Half of all mental health conditions begin by age 14, but many go undetected and untreated [2]. Proper diagnosis and treatment of mental health conditions in children and adolescents require a comprehensive understanding of their environmental and cultural contexts,

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including the spiritual and religious factors that may contribute to their illness presentation and/or be beneficial in the process of recovery.

## Christian Worldview of Children, the Family, and Child Development

In *An Introduction to Christian Worldview*, Anderson, Clark, and Naugle define worldview as "the conceptual lens through which we see, understand, and interpret the world and our place within it" [3]. As Christendom represents a vast array of denominations, there are denominational differences in beliefs and practices, emphasis on the Bible, and interpretation of Biblical text. Thus, defining a single worldview upon which all individuals who identify as Christian agree can be challenging as this may vary from denomination to denomination and family to family. However, in general, the Christian worldview affirms the importance of children and the family. In Chap. 19 of Matthew's Gospel, the disciples rebuke parents who brought their children to Jesus so that He may lay His hands on them and bless them [4]. In response, Jesus says, "let the children come to me, and do not prevent them; for the Kingdom of Heaven belongs to such as these" [4]. He then proceeds to place His hands on them. Jesus's words and actions toward children were revolutionary because children at the time of Jesus were not typically regarded as significant members of society. In Chap. 18 of Matthew's Gospel, Jesus elevates the status of children, instructing His disciples to welcome children and to seek to emulate their innocence and humility. When the disciples want to know who is the greatest in the Kingdom of Heaven, Jesus calls a child over and says, "Amen, I say to you, unless you turn and become like children, you will not enter the Kingdom of Heaven. Whoever humbles himself like this child is the greatest in the Kingdom of Heaven. And whoever receives one child such as this in my name receives me" [4].

The creation story in Genesis emphasizes the unique status of all humans as being born in God's image. Each member of a family is a person equal in dignity, including the children [5]. A child will not only have his or her basic needs met in a family but will also learn how to live in a community of faith, hope, and charity. Christian parents are meant not only to be the first teachers of the faith to their children but also to live it out in such a way that they will be examples to their children of how to love God and all people, especially the most vulnerable and needy [6]. A Christian worldview promotes the idea that Christians are not alone in life as they face life's circumstances and that the events in their lives have meaning and purpose. The values of repentance, forgiveness, redemption, love, compassion, and generosity, as well as the belief in the inherent dignity of each individual and the sovereignty of God, can be sources of strength and resilience in youth.

Many Christians believe that the relationship between God and humanity informs all aspects of life, imbuing meaning and purpose to one's relationships, identity formation, ethical values, moral code, recreation, education, and vocation [7]. Many Christian churches teach the importance of honoring parents and elders, avoiding

engagement in premarital sexual activity and drug use, viewing child-rearing as a gift and calling from God, connecting with a spiritual community, serving and working hard, providing parental discipline as an expression of love, and practicing generosity, forgiveness, and compassion. However, the specific nature of beliefs may vary between denominations and unique family systems. In the course of treatment, the influence of these beliefs may be manifest in the family system's roles and hierarchies, approaches to parenting, behavioral expectations for youth, sources of familial conflict or unity, and medical decision-making [8].

## Impact of Christianity on Emotional and Mental Well-Being

Although religious faith and spiritual practices have been identified as protective factors against suicide and depression in adults, the association is more complicated for children and adolescents [9]. Although the terms "religion," "religiousness," and "religiosity" are often used interchangeably and distinguished from "spirituality," the exact definition of these terms can vary within the literature. However, one definition is that religion refers to "an organized system of beliefs, rituals, practices and community, oriented toward the sacred," whereas spirituality refers to "personal experiences or search for ultimate reality or the transcendent that are not necessarily institutionally connected" [10]. In this manuscript, when referring to findings from studies or reviews, we use the terms that were used by the individual study authors in referring to their findings. The relationship between religiousness and spirituality and depression in children and adolescents may be both directly and indirectly mediated (i.e., through their effects on social support and substance abuse) [10]. Among adolescents with depression, those who endorsed greater use of negative religious coping, i.e., feeling that God is punishing them for their sins or lack of spirituality and negative support from the religious community, had higher depression scores [10]. Loss of faith over time also seems to predict worse outcomes in depression [10].

A review of the literature on the relationship between religiousness and spirituality and psychopathology in youth found that, in 92% of the articles reviewed, there was at least one significant relationship between religiousness and better mental health [11]. The effect was strongest in the area of substance abuse. In the case of suicidality, a majority of the articles found at least one correlation between greater religiousness and lower levels of suicidality. However, this was complicated by their finding that the relationship between religiousness and adolescent depression was ambiguous [11]. Others have hypothesized that the rising rates of suicide among adolescents and young adults may be due to the increase in social fragmentation in Western culture. Indeed, one of the reasons why religion is thought to be protective against suicide in adults is that it provides critical social networks to the believer [9].

In addition to helping them build relationships, Christianity gives youth a sense of purpose in life and hope for the future. It seems that Christianity's effects on youth are so strong in these domains that even belief in Christianity without church attendance, referred to as "implicit religion," was associated with an enhanced sense

of purpose in life in a study of 25,825 adolescents aged 15–18 years [12]. Christianity can also strengthen resilience, i.e., the process by which they adapt well in the face of adversity, which children naturally demonstrate [13]. Indeed, it may be that their very relationship with God and with others enhances resilience and adaptability in Christian young people [13].

The published literature on children and adolescents and religion/spirituality suggests that specific factors within the Christian faith and practice of the child or adolescent, the family, and the church community positively influence emotional and mental well-being. Which factors are most salient or influential can vary depending on the age of the child or adolescent. A meta-analysis of 40 studies published from 1995 to 2009 of adolescents with a mean age of 16.5 years found that religious involvement positively correlated with constructive behaviors (defined as prosocial behavior such as volunteering and positive parent-child relationships) and negatively correlated with destructive behaviors (defined as drug use, theft, and risky sexual behavior) [14]. The correlation was stronger with private religious involvement (defined as personal religious practices such as prayer or Scripture reading) than public religious involvement (characterized by religious participation and affiliation) [14]. In a study of 844 evangelical Protestant Christian children aged 7–12 years living in predominantly White and Hispanic communities in the Midwestern or Southwestern United States, 5 aspects of religious cultural context (family religiosity, religious schooling, church-based relationships with peers, church-based relationships with adults, and view of God) were examined in relation to self-esteem [15]. Since earlier literature had reported religious affiliation to be associated with increased self-esteem in children, the study examiners sought to determine which aspects of religious affiliation predict positive self-esteem. Among these five aspects, they found that self-esteem was directly predicted by a positive image of God (perceived as God being intimately present in daily life) and peer church support. Family religious practices were more significant in predicting a positive God image for younger children (ages 7–10), whereas support from other adults within the church was more predictive of a positive God image in older children (ages 9–12). Peer church support also corresponded to improved self-esteem in 11–12-year-olds [15]. Recognizing these factors can be important when a clinician is working with Christian children or adolescents as a clinician may encourage older children and adolescents to participate in church activities and/or youth group as a means of encouraging greater social support and improvement in self-esteem.

In addition to the importance of familial religious activities and church relationships, personal practices of faith for children and adolescents appear to positively impact emotional well-being. A study of 220 Appalachian adolescents, primarily White Christian (69.5%) at ages 12–18, found that 3 profiles of religiousness/spirituality (classified as “high religiousness,” “low religiousness,” and “introjectors”) exhibited different rates of internalizing and externalizing symptomatology [16]. Adolescents who had high religiousness (those with a high internal sense of the importance of faith and both public and private religious practices) had lower internalizing and externalizing pathology than “introjectors” (those whose external religious behavior was motivated by external pressure and in order to seek the approval of others but who had fewer private religious practices such as prayer or Scripture

reading). Only adolescents with high religiousness had significantly lower externalizing symptomatology than the low religiousness group, suggesting that the religious component that lowers psychopathology the most may be private religious practices such as prayer and Scripture reading [16]. Religious participation has also been associated with reduced suicidal behaviors in adolescents, although this effect diminishes with age as adolescents enter adulthood [17].

The impact of parents' practice of faith on children's emotional and psychiatric well-being has also been examined. In a study of 143 middle-school Baltimore youths (66 percent African American, 31.2 percent White), two thirds of whom were at risk for a psychiatric disorder, youth whose mothers attended religious services at least once per week had greater overall satisfaction with their lives, stronger family relationships, better skills at solving health-related problems, and greater peer support compared to those whose mothers attended less often [18]. Maternal church attendance was second only to family income among demographic factors studied (race, adolescent gender, Protestant vs Catholic, family structure, mother's education, income) in predicting overall well-being among these youths [18]. Although maternal depression has been identified as a risk factor for depression and anxiety in offspring, concordance of Christian denomination between mother and child (i.e., agreement between mother and child on which denomination to attend) decreased the risk of anxiety and depression in children and adolescents by 91%, independent of the presence of maternal depression [19].

Christian faith can also influence how parents respond to caring for children with psychiatric disorders. Parenting children with autism spectrum disorder (ASD) can be challenging and has been shown to produce higher levels of parent stress and depression [20]. However, parents of children with ASD report finding support from their religiosity/spiritual beliefs and from engaging in private prayer [21]. A study of mothers of children with ASD found that spirituality was positively associated with self-esteem and less negative feelings about parenting, and religious beliefs were associated with a more optimistic outlook [22]. In a subsequent study, Ekas et al. found in 73 primarily non-Hispanic White mothers that spirituality (described as sense of closeness with God) was significantly associated with mothers' positive perceptions of their child's ASD, ability to find benefits, and lower levels of anxiety [23]. However, mothers of children with more severe ASD have been reported to have more negative interactions with members of their church community [23]. This highlights the need for clergy to make an effort to understand and support these parents and for churches to provide respite services and activities that are sensitive to the needs of children with ASD and their families.

## Christianity and Attitudes Toward Psychiatry

Within Christian communities, families may experience stigma associated with having a child or adolescent with a psychiatric condition and with seeking treatment. In addition, they may wonder if they have not prayed hard enough, parented well enough, or somehow failed spiritually if their child rejects their faith or

suffers from a psychiatric condition. This feeling can create a sense of resentment toward their child, spouse, or God, as well as feelings of doubt, confusion, frustration, and shame. Others within their church may counsel them to pray more or may attribute the psychiatric condition to spiritual causes without taking into account biological and other etiologies of disease. Parents may also struggle with the idea of obtaining treatment, whether therapy or medication, from secular providers.

It is important to remind parents that psychiatric disorders, like physical disorders, can have a biological etiology and many have well-established neurological, biochemical, and genetic underpinnings. Although environmental and psychosocial factors can play important roles, these conditions can arise even in the most loving and nurturing of environments. Helping parents understand and recognize this may go far in allowing them to accept what their child is dealing with and in accepting evidence-based treatment. Providing psychoeducation that is sensitive to their concerns and questions and to their faith is important in establishing rapport and facilitating treatment.

That said, psychiatry addresses conditions through the lens of science. Since philosophical and spiritual questions about the efficacy of prayer, the existence of God, and the power of God to provide healing (whether through psychiatric providers or independent means) are beyond its scope, clinicians should respect a family's desire to pursue these avenues in addition to traditional psychiatric treatment. They can also, in a spirit of humility, encourage families to continue to pray for their child and for themselves and to seek spiritual support when coping with their child's condition. Respecting and being sensitive to a family's worldview and background can be critical in facilitating treatment and recovery. If a provider is a Christian, Christian families may feel encouraged knowing that their provider shares their values and worldview, understands where they are coming from, and is providing treatment from a stance that is informed and sensitive to their deeply held values. However, if a provider is not a Christian but maintains an attitude of empathic, non-judgmental, interested, and supportive listening, Christian families may also come to feel comfortable.

Within the adult literature, it has been documented that Christians may prefer treatment from someone who is Christian and may seek support from clergy or Christian counselors before reaching out to a secular psychiatric provider [24–26]. The comfort level of clergy in dealing with mental health conditions varies, depending on their own personal experience and mental health training and the nature of the mental health condition [25]. However, the number of professionally trained Christian counselors has increased significantly, many of whom have master's degrees and some of whom have doctoral degrees [26]. In a national survey of primary care physicians and psychiatrists, Lawrence and colleagues found that a physician was more likely to refer a Christian patient to a Christian counselor if the physician was Christian and if the patient was Christian and attended church regularly [26].

If a provider such as a clergy member or spiritual counselor does not have extensive psychiatric training, it is important for this provider to recognize when the

condition has exceeded his/her ability to treat and to know when to refer to or seek consultation from psychiatrically trained providers. Providing guidance and support to the family in navigating what is often a complicated, confusing, and frightening terrain and encouraging them to seek evidence-based treatments from highly trained psychiatrists, psychologists, or social workers can be helpful as they seek treatment that is best suited for their child.

## Role of Culture, Ethnicity, and Denominational Differences in Christianity and Parenting

Cultural factors associated with the family's ethnic and racial background can also influence the role and practice of faith within the context of the family and its impact on children. Christendom represents a vast array of denominations from Western-origin churches (Catholicism and Protestantism) to Eastern-origin churches which include various Orthodox churches from different countries, as well as other denominations. In addition, spiritual and moral beliefs may cover the spectrum of traditional orthodox or conservative beliefs to liberal beliefs to evangelical beliefs. Spiritual practices may also vary in terms of emphasis on personal Bible study; family religious practices; frequency of church service attendance; importance of sacraments, liturgies, or rituals; and emphasis on peer and extended social networks. It is important to understand to what degree the patient's parents or extended family members practice their faith and adhere to their specific church's teachings and whether or not this differs from the patient's own beliefs and practice.

Thus, Christian families may differ in how they view the world, family, and psychiatry. For some, the interface of psychiatry and their faith poses no challenges, whereas others may be mistrustful of psychiatry. Within the African American community, where the importance of faith, church, and spirituality as a source of strength and resilience has been well described in the literature, many church-going members may seek help from clergy before a mental health practitioner [27, 28]. Some individuals from Pentecostal or Catholic backgrounds may interpret psychotic illness through the lens of demonic possession even though the Catholic Church requires a psychiatric evaluation to be performed before any exorcisms can take place [29–32]. In addition, the practice of faith and parenting practices within families can vary depending on their cultural or ethnic context. Some individuals from Pentecostal backgrounds, particularly from African or Caribbean backgrounds, may attribute mental illness to supernatural causes such as demon possession, a punishment from God, or a result of being cursed, thereby seeking relief from faith leaders via prayer or exorcism rather than through psychiatric providers [29, 33]. Clergy within these congregations may or may not share the patient's beliefs, so exploring these beliefs with a patient and his/her family and determining if their beliefs are shared by their clergy can help the mental healthcare provider understand their context [29].

Families from Asian backgrounds may emphasize a hierarchical family structure with collectivist values in contrast to the individualist values that are present in mainstream Western culture. Stigma regarding mental illness, as it may confer shame upon the family within the context of the religious community or the extended family, may be more pronounced in some Asian American cultures and families. Within Korean immigrant families, church attendance, particularly in Korean ethnic churches, may serve a purpose in ethnic identity formation and contribute to overall well-being. In the United States, more than 70% of Korean immigrants reported attending Korean ethnic Christian churches [34]. In one study, Korean American adolescents identified Korean ethnic church youth groups as safe places in which they felt a sense of belonging and experienced identity formation in a context with peers who shared their ethnic background and religious beliefs and values [35]. Another study demonstrated that among Korean American adolescents, greater religious involvement was associated with higher personal spirituality and with lower depressive symptoms in girls and higher academic performance in boys [36]. Seol and Lee set out to determine if religious identity was a mediator of the association between religious involvement and psychosocial outcomes in Korean youth [37]. In that study of 155 Korean American adolescents, Seol and Lee found that religious socialization by parents and peers was positively associated with adolescents' religious identity and social competence. However, adolescents with low religious identity showed an increase in externalizing behaviors when they received more religious socialization from their parents, indicating that parental influence can directly impact adolescent religious identity formation. However, if adolescents did not share their parents' convictions, parental emphasis on engaging in religious practices created more dysfunction in their relationship and resulted in more externalizing behaviors [37]. This is consistent with prior literature that a difference in the depth of religious interest between parents and adolescents can negatively impact their relationship [38].

## Approach to Assessment and Practice

The optimal practice of child and adolescent psychiatry will support the holistic wellness of children, adolescents, and their families. To achieve that end, biological, psychological, genetic, and neurological factors should be assessed in tandem with cultural and social characteristics of youth and their families. Cultural issues are important to the diagnostic process as they facilitate accurate diagnosis, improve engagement and patient satisfaction, and enhance treatment response [39]. Within the cultural framework, religious and spiritual issues may play an integral role in the social, emotional, and behavioral health of patients. Indeed, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, section on Cultural Formulation includes religion and spirituality as a core component and highlights the impact of culture on identity formation and making "sense of experience" [39].

A spiritual assessment will aid the clinician in determining if religious beliefs are helpful or harmful and if spiritual interventions can be integrated into care [40].

The psychiatric assessment of children and adolescents should be grounded in an understanding of child development. Normal development processes can be categorized into distinct domains: *cognitive*, *linguistic*, *social-emotional*, and *behavioral* [41]. Cultural and contextual factors, including religion, can foster or impede normal development [41]. Religion and spirituality may exert a dynamic influence on the process of child development in Christian families. Specifically, attachment to caregivers, cognitive functioning, identity formation, separation-individuation, complexity of emotional expression, impulse control, moral development, the impact of peer influences, and problem-solving will likely be molded by beliefs about God, the authority of the Bible, and the religious leaders, rituals, and institutions. Moreover, the child's relationship to faith may also follow a developmental trajectory [40].

As with other aspects of the clinical assessment, questions regarding spirituality and religion should be asked in a youth- and family-centered, open-ended, respectful, and unbiased manner [40]. The clinician must be aware of the influence of their own personal beliefs or worldview and their potential impact on the therapeutic relationship with the child and family. Shared or divergent beliefs between the practitioner, youth, and family can positively or negatively influence treatment outcomes. In a psychodynamic psychotherapeutic context, religious beliefs, or the lack thereof, can be manifest in transference and countertransference. The therapeutic process should include informed consent regarding the disclosure of the clinician's spiritual beliefs and inclusion of faith-based treatment interventions [8]. The practitioner can elicit spiritual beliefs by asking questions regarding the source of hope and comfort in difficult times, the presence of belief in a higher power, the meaning of life and suffering, and the patient and family's important relationships, traditions, and value systems [42].

Where relevant, information regarding spirituality and religion gathered during the assessment of the youth and family should be incorporated into the clinician's formulation and be considered for integration into the treatment plan. Christian beliefs may inform the clinical presentation to varying degrees, or not be salient at all. Treatment planning should be characterized by a collaborative, flexible, evidence-informed, and patient-centered approach. Josephson posits that the most important aspect of integrating spiritual beliefs in the formulation is clarifying its promotion of wellness or psychopathology; issues of morality and meaning or purpose are generally the core spiritual elements in the formulation [8]. Christian beliefs, as with other spiritual practices, may be protective factors through the promotion of religious coping practices (e.g., prayer, Bible reading), engagement in skill building and prosocial religious activities (e.g., church attendance, volunteer opportunities, music ministry), provision of moral standards, hope and meaning, social support from a spiritual community, and promotion of healthy living [8]. Conversely, an overemphasis on sin, guilt, and shame, authoritarian parenting or religious teachings, ostracization for spiritual nonconformity, and rejection of biological explanations and evidence-based treatment for serious mental illness may be

risk factors for poor treatment response in some Christian families or communities. The therapeutic process with a Christian youth and/or family may benefit from judicious consultation with clergy of the same faith.

## Clinical Vignettes

Two fictitious clinical vignettes illustrate challenges that Christian families may encounter in clinical practice and how one might approach these.

### *Vignette 1*

Kristy is a 16-year-old girl whose parents are Protestant Christians, active in their local church, and who have talked about the importance of faith in their sessions with her psychiatrist. Her psychiatrist is not Christian but has listened empathically to Kristy and her parents as they have shared how their Christian faith and church community are important to them. The psychiatrist has developed a good rapport with both Kristy and her parents over the course of treatment. Kristy initially presented for the treatment of ADHD at age 11 when she was struggling academically. She has been treated with medications specific for ADHD and has since done very well academically and socially. Recently, Kristy's parents brought their concern that since she turned 16 and began driving, they have noted a shift in her behavior and discovered that she is sexually active, increasingly defiant, often engaging in arguments with them, staying out late at night, and no longer interested in attending church. She has told them that she does not identify as a Christian. They raise their concerns about how they should respond as parents. On interview, when alone, Kristy states she finds her parents overbearing and hypocritical and that they do not understand her.

When working with children and adolescents, it is critical that the clinician gain the trust of both the parents/caregivers and the child/adolescent, without overly aligning with either party at the cost of alienating the other. Clearly, the clinician should approach this situation with tact, gentleness, and a non-judgmental attitude, seeking to listen to both parties and aiming to improve communication and understanding between the parents and Kristy. When conflict centers on spiritual matters, parents may feel conflicted as they are torn between what they perceive as their allegiance to God and their support of their child. If a child or adolescent is rejecting his/her parents' deeply held religious views, helping the parents understand this in a way that allows them to uphold their values but still love and accept their child is critical in helping them repair or preserve their relationship and in promoting the health of the child or adolescent. Clinicians may need to remind parents that spiritual values need to be held intrinsically by their child and cannot be coerced and that outward demonstrations of religious practice in the absence of inwardly held values

are of little benefit and may even be detrimental. It may also help to encourage them to rely on the resources of their church community, faith, and prayer instead of trying to argue with a child or adolescent to produce spiritual change. The clinician can discuss with the parents whether there is a youth group or youth leader with whom their child can connect who may also be a positive influence. The clinician should support the parents in their efforts to provide structure and expectations around safety (such as curfew, needing to know their daughter's whereabouts, and with whom she is in contact) and encourage them to engage in positive interactions with their daughter apart from activities or discussions centered around faith. The psychiatrist should remind the parents that repairing their relationship with their daughter is most important here. Repairing their relationship with their daughter may allow them to explore topics of faith at a later date. If a clinician ignores, ridicules, or dismisses the parents' values or concerns, this will not bode well for treatment success and may rupture the treatment alliance.

In this instance, since Kristy's behavior may be associated with other risk factors, the clinician should explore her relationships within the family, relationships with peers, and academic and emotional functioning. This includes whether she has engaged in risk-taking behavior such as drug use, alcohol use, unprotected sexual intercourse, or being in situations where her immediate safety is at risk. The clinician will want to screen for other psychiatric conditions such as depression, determine if Kristy has been taking her ADHD medication, and determine if there have been changes within the home environment that could contribute to her strained relationship with her parents and her changed attitude toward faith. Adolescence is often a time during which youth seek to individuate from their parents, desire greater autonomy, and seek to form their own sense of identity, values, and purpose. In addition, peer influences can have a great impact during the adolescent years. How parents respond to their child can also affect their relationship and, subsequently, influence how their child relates to their faith. Exploring with Kristy, in a confidential and non-judgmental setting, what has shifted and produced these changes in her behavior and views is critical for healing, but the clinician should do so while respecting Kristy's autonomy and ability to make her own decisions regarding faith.

## *Vignette 2*

Josephine is a 16-year-old daughter of devout Catholic Haitian immigrants who was referred for a psychiatric evaluation by her Haitian-American parish priest, Fr. Louis. Her parents were initially reluctant to bring her for an evaluation but ultimately decided to follow their priest's advice. They discovered that she had sent naked pictures of herself to a boy in her class. She was ashamed of her actions, and her parents encouraged her to go to the priest for the Sacrament of Reconciliation (confession). Throughout her school age years, Josephine was a vibrant, social, and intelligent girl who was always compassionate to those most in need. As a teenager,

she seemed socially anxious and isolating. She had a history of vocal and motor tics around the age of 8 or 9 that her parents reported had gradually gone away by age 12 without any intervention. They didn't feel that these tics were pathological since there were children in her parents' village in Haiti who exhibited similar behaviors. Some of those villagers practiced Vodou and would bring children with these symptoms to the temple for consultation with the priests or priestesses about healing rituals with varying success.

After she turned 14, she became more emotionally reactive than any of her sisters had been at that age. In the fall, she refused to attend school for a week, initially reporting abdominal pain so that she could remain at home. During that week, she lay in her bed continuously and slept much more than usual. Her appetite was also markedly decreased. She said very little to her parents when they attempted to talk with her. When they discussed her transition back to school, she responded by yelling and screaming. She begged them not to send her back but would not tell them why. They were persistent and explained that she would lose privileges if she didn't return to school. She then started having episodes during which she would collapse to the ground and convulse. After these episodes, she was able to talk normally with her parents and resume her usual activities. Over time, these episodes subsided but would occasionally recur during times of stress. She was never able to discuss her stressors with her parents.

With her parents' consent, Josephine's new psychiatrist, Dr. Lloyd, spoke with Fr. Louis to better understand the intersection between the patient's psychopathology and her and her family's religious and cultural background. Fr. Louis knew Dr. Lloyd because he had referred several patients and families to him. Dr. Lloyd was himself a practicing Catholic, and this greatly facilitated their conversations about Josephine. Dr. Lloyd had even started to regularly perform the required psychiatric evaluations of individuals that would help rule out psychopathology in individuals being considered for formal rite of exorcism by the diocesan exorcist. The diocesan exorcist is a priest appointed by the bishop to perform the rite of exorcism.

Fr. Louis shared her story with Dr. Lloyd. He had directly observed one of her convulsive episodes and recalled that, during this episode, she continued to speak and said that she was a demon named Jean-Pierre. Her parents asked if she needed an exorcism. Although the priest didn't think this was the case and was about to refer directly to Dr. Lloyd, Josephine's parents insisted that the bishop be consulted first. The bishop observed one of her episodes which he thought looked atypical for demonic possession. He prayed for her, gave her and her family his blessing, and explained that he did not believe she was possessed by a demon. The bishop suggested she undergo a psychiatric evaluation with Dr. Lloyd. The parents were still reluctant to do so. They talked to a family friend from Haiti who was himself a physician and decided to have her examined by a neurologist first. The neurologist conducted an evaluation to rule out epileptic seizures, including inpatient 24-hour video-EEG monitoring, and diagnosed her with psychogenic non-epileptic seizures (PNES). She recommended consultation with a psychiatrist.

Fr. Louis also told Dr. Lloyd that he suspected that something inappropriate had transpired with one of her older male cousins when they traveled as a family to visit

Haiti when she was 14. After interviewing Josephine's parents and meeting with her alone for several sessions, Dr. Lloyd concluded that her behavior was most consistent with a post-traumatic reaction, albeit subthreshold for a formal diagnosis of PTSD. Josephine had not disclosed to Dr. Lloyd the full details of what had happened on the trip, but its impact upon her emotionally and interpersonally was unmistakable. He informed them that her periods of low mood, isolation, and school refusal seemed consistent with a depressive episode and that medication may be an option in the future if this episode recurred. She began seeing a female, Haitian-American therapist to whom Josephine eventually disclosed having been sexually assaulted by her cousin. As she made progress in therapy, school attendance improved as did emotional engagement with her family and friends.

This case illustrates the complex interaction among faith, culture, and psychopathology. When working with immigrant or minority populations, it is important not to assume that an individual patient will necessarily practice the faith that the majority of people from his or her culture of origin practice or that his or her faith will align with that of their family. In this case, there was an alignment between the faith of the psychiatrist and his patient's family. This can indeed be fortuitous as it can deepen the psychiatrist's understanding of the salient factors that need to be taken into account before attempting to diagnose or treat these patients. It can also make it easier to consult with clergy or other individuals involved in the patient or family's pastoral care/spiritual direction. If the patient in this case were rejecting her family's Catholic faith, the psychiatrist's Catholic faith may have made it difficult for her to trust him. It is important to be honest with patients and families if they inquire directly about an individual psychiatrist's faith, but the decision about whether or not to disclose one's faith without being asked is inherently complicated and depends on the impact that this will have on patients and families and the psychiatrist's comfort in doing so. It is somewhat less complicated to disclose that a psychiatrist has the same cultural background as a patient because the psychiatrist's physical appearance, name, or accent may already be identifiable to patients and families before the psychiatrist begins such a discussion. A shared cultural background can deepen mutual understanding; however, it could also be a liability if the psychiatrist is a member of the same local community or church as their patients. This could make the patient feel that they can't trust their psychiatrist for fear that they may disclose the patient's problems to others.

**Clinical Pearls**

- Follow the family's and patient's lead. Some families may identify as Christian, but their faith does not impact their daily life, their beliefs do not seem to have bearing on their child's treatment, and/or they do not feel comfortable sharing these beliefs with the clinician.
- Other individuals may report that their faith is very important to them, and the parents and/or child will bring this up in treatment. They may share how this affects their relationship within the family, the values they want to instill in their child, their extracurricular activities, and/or their expectations within the home. Listening, encouraging, and supporting these beliefs and intentions when adap-

tive are helpful. Providing developmentally sensitive guidance to families when the child's behavior or experience is in conflict with parental values can also help.
- Encouraging families to develop positive relationships with members of their larger community (e.g., church and youth group) can be beneficial in providing support for the child or adolescent and for the parents, in promoting positive self-esteem and positive identity development for the child, and in promoting shared understanding and values between parents and children.
- For parents who are Christian who may be hesitant about seeking psychiatric care for their child, emphasizing that psychiatric treatment and spiritual efforts can be complementary and do not have to be in conflict can aid treatment progress.

## Summary and Conclusions

In summary, spirituality and religion may be important factors in the lives of children and families who present for psychiatric care. Specifically, Christian faith may exert a significant influence on child development, the manifestation of psychopathology, and family dynamics. A review of relevant literature indicates that spiritual beliefs correlate with improved mental and emotional health if the youth has a supportive faith community, positive parental influences, and a positive view of their relationship with God. Implicit religious practices are associated with a strong sense of purpose, increased resilience, healthy self-esteem, improved parent-child relationships, and prosocial behavior. Ethnic, racial, and cultural factors may inform the expression of religious faith. Christian families may grapple with stigma associated with mental health treatment, pursue counseling and support from clergy for psychiatric issues, and communicate spiritual explanatory models for psychopathology. The mental health practitioner should provide empathic, ethical, evidence-informed, and non-judgmental psychoeducation in this context. Collaboration with clergy, with informed consent, may support the integration of faith and psychiatric care. Practical considerations for clinical practice include following the lead of families and youth regarding the integration of Christian faith in treatment planning and encouraging the positive aspects of faith, such as community support and hope.

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# Chapter 6
# Trauma


**Nadine Nyhus**

## Introduction

The goals of this chapter are to lay a foundation for providing trauma therapy to Christian clients, to propose an approach to treatment that integrates discoveries from neuroscience, and, finally, to discuss obstacles and resources for Christians in trauma therapy. Achieving these goals will require integration of Christian faith with findings about the neuroscience of trauma. Given that only 37% of psychiatrists identify as Christian (compared to 61% of their physician colleagues [1] and 65% of the general population [2]), I will also be careful to keep in mind the challenges that present when the clinician does not share the faith of the patient.

*Posttraumatic Stress Disorder (PTSD)* and trauma have become hot topics in psychotherapy and counseling. There is a plethora of new research and books being published on trauma. Much of this literature emphasizes the critical role that the *body*, and specifically the *autonomic nervous system (ANS)*, plays both in the experience of trauma and in effective trauma therapy [3–7].

Despite the fact that over 200 million people in America identify as Christians, there are unfortunately few resources written from a Christian perspective that incorporate the role of the body in treating trauma [8–10]. I obtained a master in theology prior to training in psychiatry and subsequently in five methods of treating trauma. Over the last 25 years of clinical practice, I have worked with pastors and church leaders to optimally integrate faith with mental health treatments for trauma which both I and patients have found highly effective.

Christian churches, like mental health treatments and Western culture in general, tend to emphasize a cognitive approach to problems. Indeed, an abundance of evidence demonstrates that cognitive therapies and approaches are highly effective [11]. However, within the church as in the mental health field, there has been a growing

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recognition that emotions can receive short shrift from the emphasis on cognitions. Peter Scazzero's groundbreaking and highly influential book, *Emotionally Healthy Spirituality*, addressed this issue and accorded emotions the respect and recognition they demand and deserve. His statement "It's impossible to be spiritually mature while remaining emotionally immature" exemplified the interdependent relationship between faith and emotions [12]. This contention highlights the unity of the human person, that is, maturity and health involve all of who we are.

Now that emotions are on the radar screen, an important next step for the church and for Christians is to consider the role of the body in healing from trauma. The body is central not just because human beings are a unified whole, but more specifically because trauma's impact is mediated to a large degree through the physical body, specifically the ANS. Thus, based on neuroscience, I strongly advocate for an approach to treating trauma that prioritizes equipping patients to regulate their ANS first, followed by regulating emotions which track closely with the body, and lastly by restructuring negative cognitions. This is not to say that emotions and cognitions are unimportant. Rather, it is to say that they both settle significantly when physiologic arousal in the body, more specifically the ANS, settles. As a result, despite the importance of working with emotions and cognitions in trauma therapy, this chapter will focus on treating the fallout of trauma in the body as the foundation for healing.

## Definitions

### *Integration*

Integration is the process of bringing together distinct areas or entities into a functioning whole. Here our project is to coordinate knowledge and insights from two different spheres, neuroscience/mental health and the Bible/Christianity, in a way that does not invalidate either sphere. For Christian patients this means incorporating findings from neuroscience and mental health without contradicting the Bible or compromising their faith. It may also involve challenging ways in which trauma has blocked patients from experiencing potential resources in their faith, such as those discussed at the end of this chapter.

Just as integration can be challenging for the Christian patient, it can be equally challenging for the treating non-Christian clinician. When sitting with a Christian patient who respects the value of neuroscience and mental health treatments, a critical question for a clinician who does not share the patient's faith is, "Can the Bible be a valid source to use in discussing, understanding and applying the science of psychiatry?" Whether a clinician truly respects their patient's religion, and indeed their patient, comes out of the answer to that question. To respect a patient's religion is to do more than recognize the value of religion as a hobby or a charity. It is to

consider the possibility that a biblical view of the human person, the world, and God could be coherent and exhaustive enough to underpin a mental health journey.

Here we are considering the issue of worldviews and the reality that all worldviews, materialist and humanist as well as religious, involve underlying presuppositions that cannot be empirically proven. This is, therefore, an issue of integrity for the clinician – is the clinician willing to recognize the unprovable nature of their own presuppositions so that they can allow room for different unprovable presuppositions held by the patient? One hopes that the traumatized patient will not be expected to bear the additional challenge of respecting the worldview of the therapist. The patient will likely be adequately challenged by considering how to incorporate the discoveries of neuroscience and effective secular mental health treatments into their healing.

## *Christian*

As will become more obvious as we proceed, having a baseline for what is understood by the term "Christian" is helpful both because it opens the possibility for the clinician to encourage the mobilization of resources in this belief system and also because it affords ways of challenging the patient's distorted and unhealthy ideas that are at odds with that same belief system. The term is used to describe a wide variety of entities (a worshipping community, a culture, or a nation) and beliefs (Eastern Orthodox, Roman Catholic, and a myriad of Protestant denominations). In this chapter I will not be delving into denominationally specific doctrines, and I do not claim to have a corner on what "true" Christianity is. Rather, I use the term Christian to refer to a patient whose personal belief system is based on the Bible, specifically the New Testament.

The discussion here will have as a foundation a respect for the Bible and how Christians have commonly understood it for its 2000-year history, as reflected in the Apostles' Creed [13] and the Nicene Creed [14], the two earliest and most widely adopted creeds in the history of the Christian church. These creeds lay out the core of Christian orthodoxy as belief in one triune God, a single deity existent in three persons: God the Father; Jesus Christ the incarnation of the triune God who lived a life without sin, died in the believer's place to restore relationship between the believer and God, rose from the dead, and will come again; and the Holy Spirit who indwells and empowers the believer.

In this chapter, we will be looking at specific passages in the Bible. Any quoting of a biblical passage raises the larger question of how that passage should be interpreted, a field of study called hermeneutics. I will not take a position on hermeneutical issues such as whether Genesis 1–3 is a literal description of what happened in the history of humanity with one man named Adam and one woman named Eve, or a non-literal description of a fundamental reality of human existence, the presence of sin and evil in the world. However, I will take seriously the commonly held Christian doctrines of sin and the fall as presented in Genesis 3, elsewhere in the

Bible, and throughout church history. This approach is consistent with the fact that many Christians agree on the nature of sin and evil without agreeing on how exactly to interpret Genesis. There is also a need to clarify what it means for a person to identify as a Christian. This chapter focuses on intrinsically motivated Christians for whom faith is a central organizing element in life, rather than on those who are extrinsically motivated [15].

## *Trauma*

We use the term trauma to mean exposure to one or more overwhelming situations that leave the recipient both feeling powerless in the moment and with ongoing fallout related to hypersensitivity to potential or imagined danger associated with increased *autonomic nervous system (ANS)* activation. This fallout is often called *triggering* because it commonly involves smaller, non-traumatic experiences in daily life that trigger a disproportionate emotional and physical reaction due to a large release of adrenaline in the ANS. This definition of trauma is broader than that of PTSD in the *Diagnostic and Statistical Manual* (DSM), which requires the precipitant trauma to be an "exposure to actual or threatened death, serious injury, or sexual violence" [16].

Unfortunately, many experiences of incest and sexual abuse would not meet the DSM definition of trauma in PTSD, so that no diagnosis can be made even if all the fallout criteria are present. Similarly, much childhood emotional abuse and neglect would not qualify as PTSD trauma even though these experiences can manifest with a full complement of fallout symptoms. It is a source of significant controversy that up to the present time, the DSM has included neither a developmental trauma diagnosis [17] nor a complex PTSD diagnosis (first proposed in 1988 [18] and included in the ICD 11 in 2018 [19]) related to more prolonged, interpersonal trauma that would capture childhood sexual abuse.

The broader definition of trauma used in this chapter, while capturing cases missed by the PTSD diagnosis, may raise concerns about labelling insignificant experiences as traumatic. Indeed, the Adverse Childhood Experiences (ACE) Study [20, 21], involving over 17,000 middle-class adults in 2 phases, using a survey with questions on broad areas of childhood trauma, found a high prevalence of childhood trauma at 64%. This is significantly higher than the 6–9% lifetime prevalence rate of PTSD in the United States and Canada [22]. However, this does not mean the ACE Study was including inconsequential trauma. The participants captured by the broad definition were at significantly elevated risk of medical and psychiatric illnesses [23]. Other studies have confirmed the association between child abuse and medical problems in adulthood [24, 25]. Given that the goal of this chapter is to empower anyone with fallout from trauma, a broader definition would seem appropriate.

So, in this chapter, trauma will be understood as an experience that overwhelms a baby, child, or adult with feelings of powerlessness and that results in classic

fallout symptoms, including re-experiencing symptoms (through triggering), negative thoughts, negative emotions, and avoidance. Examples include combat experiences, natural disasters, severe accidents, assault, birth complications, illness, and surgery as well as physical, emotional, and sexual abuse. It is important to note that even physical or emotional neglect can be traumatic if children feel overwhelmed and powerless as they strive to take care of themselves.

## A Biblical View of Trauma

Numerous Greek (i.e., pathema, pascho, lune) and Hebrew words (i.e., ka'ab, chebhel, yaghon, makh'obh) are used in the Bible for what I am calling trauma. In a Christian context, the English word suffering is most commonly used to capture what I am calling trauma. A theology of suffering, a view of suffering that includes God, is spoken of and written about extensively [26–30] and is seen as central in Christianity, just as Christ's death by crucifixion is central. In the opening pages of the Bible, the text addresses suffering. Genesis 3 describes what Christians since Augustine of Hippo (354–430 AD) have termed "the fall" [31], which is the Bible's explanation for suffering and trauma: humans who were created by God with freedom to choose, chose to disobey Him and go their own way. Further, God allowed them to make that choice, even though it had dire consequences. He did not force obedience. As a result, we have a world full of pain and suffering, a fact which the Bible documents in brutal detail from the first murder (Gen 4) to the death of Stephen, an early church leader, by stoning (Acts 7).

Thus, human freedom as well as that most reviled against concept in Christianity, sin, become the foundation of the Christian view of suffering and pain. So, much that happens on earth is not what God originally intended and is not a reflection of His heart of love for humanity. Rather, evil, pain, and suffering are consequences of our turning away from Him and doing what He has told us not to do. Not only are humans seen as fallen in the Bible and Christian theology, but also the natural world. Romans 8:22 says, "the whole creation groans and suffers" (NASB) as it waits for redemption. So natural disasters may also be viewed as being a result of the fall.

However, all this is said from a distance, speaking conceptually about the start of suffering and evil. Yes, back then, humanity disobeyed and out there in the world bad things happen. However, for an individual Christian who is experiencing pain/suffering/trauma, abstract concepts about a fallen world do not suffice. Instead, very personal questions arise: "Why me?" "Did I do something to cause this?" All victims of trauma, whether they believe in a personal, loving God or not, struggle to find meaning in their suffering. For a Christian, more specific questions may arise: "Does God love me?" "Is God not pleased with me?" "Is this punishment for my sin or my lack of devotion?" This is where the rubber meets the road. For someone who believes in a God who is all-powerful and loving, experiences of trauma can feel like a personal betrayal or abandonment by God.

The Bible's answer to this is a person – Jesus Christ. At the very heart of Christian theology is the second person of the Godhead who took on human flesh, suffered, and died on the cross in our place, paying the price (alienation from a holy God) for our sin and knowing the depths of suffering so that He can be with us in our suffering. The Bible encourages believers to find comfort in the presence of Christ, knowing His love by what He suffered for them and knowing He can empathize with their suffering. Then to go on to comfort others with the comfort they have in Christ and God (2 Cor 1).

## A Neuroscientific View of the Body

From the view of neuroscience, the ANS is central to healing from trauma. The ANS is the system in our body that executes our response to threat. The ANS has two branches: the sympathetic branch which activates via adrenaline release and the parasympathetic branch which opposes or dampens the sympathetic activation primarily via the vagus nerve. When the sympathetic branch is stimulated, it revs up the system like pushing on a gas pedal. When the vagus nerve is stimulated, it settles the system like putting on a brake. In addition to many web articles, there are whole books written now on how to stimulate the vagus nerve [32, 33], since settling the ANS is so important in health.

Adverse experiences in childhood, when the body is developing, are particularly consequential. They are a key risk factor for developing medical and psychiatric illnesses (as noted above) as well as for developing PTSD from a later adult trauma [34–36]. Why is childhood trauma so important? The human ANS develops in the context of relationships in childhood. Recent neuroscience confirms what Attachment Theory has maintained since the 1950s, that we are fundamentally relational creatures [37]. A baby comes into the world oriented to making connection with others [38], and safety through this connection is essential for growth and health [39, 40]. Young children are physically, emotionally, and cognitively unable to manage life on their own. They need *co-regulation*, the reliable presence of a supportive adult helping them manage psychological and physical distress and danger.

A lack of co-regulation in childhood results in a less robust vagal brake and an ANS that is more vulnerable to being overwhelmed as evidenced by decreased heart rate variability (HRV), which indicates less vagus nerve activity [41, 42]. This vulnerability persists into adulthood. The good news is that adults, even those who did not receive much co-regulation in childhood, are able to self-regulate their ANS. Slow breathing is the most common and, arguably, the most reliable method of settling the ANS [43, 44]. Research evidence points to stimulation of the vagus nerve as the mechanism for the settling effect of slow breathing [45]. This is why I advocate starting trauma treatment with the body, specifically with learning to settle the ANS by slow breathing. With practice, slow breathing can settle ANS activation even in stressful or triggered situations. Mastery and empowerment develop as

patients have a lived bodily experience of being able to settle their ANS consistently. Healing from trauma is a journey into empowerment as the main dynamic in trauma is disempowerment.

## A Christian View of the Body

Before moving on to outlining the treatment of trauma, consider how Christians might respond to this focus on the body. As already noted, Western Christians tend, like the rest of Western culture, to be cognitively oriented, resulting in a tendency to emphasize cognitive approaches to emotional problems and to overlook the body. But is this approach consistent with the Bible?

Ancient Jewish culture had an integrated view of the human person. God created humans with a physical body and said it was good (Gen 1:31). The New Testament consistently speaks about humans having a body in the afterlife (I Cor 15:42–44, Phil 3:21). So, embodiment is not something Christians escape, even in death. Embodiment is also profoundly validated in Jesus' taking on human flesh and continuing to have a resurrected body.

A biblical respect for the body and for the unity of the human person provides solid support for accepting the neuroscience evidence that the body carries trauma. The Bible describes humans as being formed and woven in the womb by God – as "fearfully and wonderfully made" (Ps 139:13,14, NASB). Christians can see in God's design of the body an innate drive to heal in the way platelets, clotting factors, and fibrinogen are drawn to the site of a cut for repair. They should not be surprised that there is also an innate drive in the ANS to heal from trauma. Christians can learn from neuroscience that there is a reliable, predictable way to settle the ANS and to learn to live in a more regulated state.

## Treating Trauma

Through practicing for 25 years, I have come to conceptualize two goals in trauma treatment: first, better managing of triggering in daily life and, second, processing past traumatic experiences. Consider each of these.

The first goal, learning to manage triggering, is an option for everyone even if one's daily life is chaotic and stressful. It does not stir up additional activation or pain. Rather, it involves developing competence at settling one's ANS. As noted above, this is done effectively through slowing down breathing, which appears to work by stimulating the vagus nerve. This calming process can be enhanced by adding other ways of stimulating the vagus nerve [32, 33] or other calming activities such as music, imaging a safe place, being out in nature, and, for Christians, engaging in spiritual practices that support an experience of God's love and peace. I give my patients homework to practice slow breathing four times a day, 25 breaths

at a time with the goal of breathing 10 seconds in and 10 seconds out [46]. Once a person can do slow breathing when calm, then breathing can be used when triggered until confidence is gained that the ANS can reliably be settled in most situations.

An example of the power of addressing the needs of the ANS first is a 52-year-old divorced woman I saw recently. She met diagnostic criteria for PTSD. Although recurrent nightmares of her father's violence had settled, she presented during the COVID-19 pandemic with insomnia, waking early in a panic attack most mornings, and feeling panicked all day. She stated in desperation, "My whole life is a trauma; it is ongoing. I am desperately trying to create safety for myself (by organizing) but there isn't enough time." After practicing slow breathing together, she did this breathing consistently at least four times a day. Her insomnia improved dramatically. She stated in our fourth session, "I feel empowered by taking ownership of my body, and I haven't felt empowered for so long!"

When the ANS settles, triggered negative emotions and thoughts follow to a significant degree. However, I also give patients specific resources and coaching in how to regulate negative emotions by validating them. Faber and Mazlish's book [47] on how to validate children's emotions is the most practical source I have found on teaching how to validate emotions. The book is written to teach parents to validate their children's emotions. However, the principles are very applicable to validating anyone's emotions, including one's own. Additionally, I coach patients on how to regulate negative thoughts by challenging and restructuring them using thought records. Mind Over Mood [48], a popular Cognitive Therapy self-help workbook that has been much used for 25 years, contains an excellent explanation of thought records.

Notice the order: the ANS is settled first, next emotions are soothed, and then the cognitive work is done. Making the body the starting point and foundation for treatment has been the most dramatic change in how I treat trauma. Years ago I focused on cognition, but now I understand and have experienced over and over how impotent cognitive approaches are when the ANS is activated. However, once the ANS is settled and emotions are respected and validated, cognitive restructuring remains a powerful intervention. This is all the first goal of treatment: managing in one's daily life.

The second goal of treatment, processing past traumatic experiences, requires some capacity to tolerate activation as it involves going into past pain, if only briefly, in order to process it. Digging up past pain is contraindicated for patients in crisis, so processing past events requires moderate stability in one's daily life. Having some confidence in regulating emotions is an important preparation.

There are many approaches to processing past trauma. Somatic Experiencing (SE) Therapy [49–51] focuses on trauma as it is stored in the body in the form of tension and thwarted self-protective responses. Other trauma therapies track bodily responses but focus more on the plasticity of memory and the power of the human imagination. Prolonged Exposure (an adaptation of Cognitive Behavioral Therapy) [52, 53], Eye Movement Desensitization and Reprocessing (EMDR) [54–56], and Emotion-Focused Therapy for Trauma (EFTT) [57–59] seek to infuse traumatic

memories of childhood powerlessness with one's current adult empowerment. Other therapies work to replace traumatic memories with positive ones, as in Accelerated Resolution Therapy (ART) [60–62], or to create new positive memories of needs being met by an ideal mother or father as in Pesso Boyden System Psychomotor (PBSP) Therapy [63–65]. Exploring these methods of processing past trauma is beyond the scope of this chapter, but online resources and training opportunities are available as referenced above. The main takeaway is that trauma, even childhood trauma, is very treatable.

In regard to medication, if a patient presents with or develops clinical depression during trauma therapy, I offer antidepressant medication. I track patients' mood through depression scales and generally find that mood improves as a sense of empowerment increases. If nightmares are disrupting sleep, I have found prazosin to be helpful for some. However, regulating before going to sleep and imaging an empowered ending to recurrent nightmares are very effective. In general, I do not use medication in treating trauma. In particular, I limit benzodiazepines to a single pill that can be kept in the back pocket for the hypothetical triggering or panic attack that cannot be settled by regulating the ANS.

## Obstacles for Christians in Trauma Treatment

### *Slow Breathing Is Not Talked About in the Bible*

Having established a neuroscience foundation for starting with the body, how will the typical Christian respond to starting therapy by learning to settle the ANS by slow breathing? I had one pastor ask simply and directly "What would St. Paul say about this?" (St. Paul is understood to be the writer of many of the letters to churches which have become books in the New Testament.) This question brings up the issue that the Bible does not instruct believers to do slow breathing. However, there is also no instruction in the Bible on healthy diet or the need for exercise, two things that Christians readily undertake as part of a healthy lifestyle without being directly told to do so in the Bible. This highlights the fact that Christians are already integrating modern knowledge with their faith every day.

What the Bible does talk about is being "still." Psalm 46:10 instructs, "Be still and know that I am God" (NIV). This recognizes that knowing a God beyond the material requires disengaging from the material stimuli that barrage our five senses. Neuroscience brings to the modern person evidence for the need to become still and effective ways to do so.

This obstacle is related to many Christians' reluctance to be treated by a non-Christian mental health professional. Since psychiatry and subject matter brought up in mental health settings are not specifically talked about in the Bible, they are sometimes suspect. Working this through is helped by the clinician demonstrating an approach to integrating the patient's faith with their healing from trauma.

### *Breathing Practices Are Found in Other Religious Traditions*

There are Christians who are fearful of anything practiced in other religions and in modern spiritualities. The most notable examples are spiritualities in what is termed the New Age Movement that tend to be connected with Eastern religious traditions and their associated worldview [66]. Christians' anxiety can include a fear of slow breathing because yoga, an ancient practice originating in Hinduism, is known to focus on the breath. One only needs to go online to find many leaders of trauma therapies who overtly espouse Eastern religious beliefs while promoting breathing and learning to regulate the ANS [67]. However, this need not concern a Christian. These leaders and their followers are simply integrating their a priori assumptions and worldviews with neuroscience, as I in this chapter am encouraging Christians to do.

The ANS's response to breathing can be just as easily understood in the context of a Christian theology of the human person. The biblical concept of design makes sense of the fact that people from any religious tradition can recognize that the body settles with slow breathing; from a Christian perspective this is simply a reflection of how God designed the body. To eschew such a basic aspect of the functioning of our bodies, when it is part of God's design, would be tragically limiting.

### *Only God Can Heal*

This passive view of healing is often applied inconsistently by Christians who hold it. They may not question going to the doctor for antibiotics or having surgery for appendicitis but put emotional healing and mental health issues into another category. It is as if every organ in the body can be ill or dysfunctional except the brain and nervous system. When Christians over-spiritualize mental health healing, they may be uncomfortable with an approach that starts with the body and regulating the ANS. An over-spiritualized approach sees healing of mental conditions as requiring miraculous events in which God intervenes in a believer's life and changes it in a way that is humanly inexplicable. Christians may long for this kind of experience as a validation of their worldview and, more personally, as a validation of God's love for them.

These ways of thinking carry great risk. First, the believer is taking on a passive posture by believing their only hope is a miraculous intervention from God. Passively waiting for God to take away the effects of trauma also reinforces the problematic powerlessness that trauma inculcates – perhaps one reason it can feel right to the traumatized Christian. However, the Bible does not speak about the human journey as being passive: "Work out your salvation in fear and trembling" (Phil 2:12, NASB) and "You have not yet resisted to the point of shedding blood in your striving against sin" (Heb 12:4, NASB). God has created humans with agency and responsibility, to steward the earth (Gen 1:28), and to be held accountable for

sin (Hos 8:13, Heb 9:27). The Bible encourages dependence on God, but in the form of an active, not a passive, dependence (John 15). Believers are likened to a body, with each member of the body having a different gift, all responsible to use their gifts for the good of the community (I Cor 1, Eph 4:16).

In emphasizing the need for agency, one need not deny that God can intervene in a person's life to bring about dramatic change and healing. For example, people have experienced remarkable relief from substance abuse, including from cravings, after a spiritual encounter. However, these significant shifts do not mean the healing journey is over. The longing to have "arrived" and be "finished" is widespread, and no wonder! The healing journey is painful and hard work. The Bible brings meaning to this work – that suffering brings Christians to the end of themselves and tutors them in a relationship with God from which they can actively draw strength for daily life.

## *Use of the Bible to Shore Up Denial*

One established step in healing from trauma, as in healing from anxiety/panic attacks/phobias, is to face and work through the pain, powerlessness, and fear it has instilled. This involves re-experiencing negative feelings and bodily sensations. Clearly this is challenging, so it is typical to hope the damage from trauma would "just go away." Consider some of the ways that Christians can justify their avoidance or denial with the use of scripture:

### It Is Wrong to Look Back at the Past

It is not uncommon to hear Christian patients quote Phil 3:13, "forgetting what is behind and straining toward what is ahead" (NIV) as a reason why they should not look into their past. However, Paul, the apostle writing Philippians, was referring to not putting stock in the acclaim he earned from his zealous legalism as a Pharisee, quite a different thing from processing childhood trauma. When patients quote verses like this to me, I find it helpful to explore the context, an approach reflective of taking the Bible seriously.

### It Is Wrong to Identify Weaknesses and Character Flaws in One's Father or Mother

Perhaps the most common Bible verse that I hear patients quote as a reason for not discussing childhood pain is some rendition of Exodus 20:12, the fifth commandment, "Honor your father and your mother" (NASB). Patients often seem to believe that it is dishonoring to realistically acknowledge their parents' weaknesses and strengths, as if honoring requires idealizing. In fact, I find that idealization and denial

of weaknesses result in ongoing disappointment and resentment which makes it harder to treat parents with respect and honor. I tell patients at the beginning of therapy that their relationships with their parents will most likely improve as they learn to regulate themselves, starting with their ANS, and move into a mature posture of realistically acknowledging their parents' strengths and weaknesses. Research on adult attachment confirms that the inability to realistically discuss parents' weaknesses is associated with insecure attachment. Healthy, securely attached adults are those who can realistically list strengths and weaknesses of their parents [68].

What is this denial of weaknesses about? When parents are not adequate, children often cope by developing an idealized view of their parents. This view persists into adulthood when adults continue to long for parents to meet deep needs that were not met in childhood – needs that one's parents are no more likely to meet for the adult child than they did for the young child. Continued disappointment feeds resentment and conflict when parents do not change and become more affirming. As patients learn through self-regulation that they are able to comfort their own pain and validate needs their parents failed to meet, they can let go of expectations and accept their parents' weaknesses. With this tends to come a greater appreciation for their parents' strengths, which enables them to honor their parents more.

### Being a Good Christian Means Being "Nice"

There can be a strong Christian cultural expectation to be nice, meaning to not be contrary or confrontational and to not talk about negative things. Often no specific Bible verse is quoted to punctuate this rule; the fact that it is more subtle and pervasive may make it more challenging. The pressure to be nice resonates with and exacerbates the dynamics of trauma and thus impedes the healing journey. A commitment to being nice handicaps Christians from having healthy boundaries, practicing healthy self-care, and acknowledging the presence of trauma in their life. Trauma itself, with the lack of safety and lack of a strong sense of self it engenders, can underlie conformity to being nice. In turn, the expectation to be nice reinforces the loss of empowerment and loss of voice that comes with trauma. This exacerbates "people-pleasing" and a need to perform to feel valued, which is inconsistent with the fundamental principle of being loved unconditionally by God. The New Testament commands Christians to be loving, but speaking the truth is included in love and is a means to mature spiritually (Eph 4:15). And Jesus modeled this in being bold and challenging (Mat 21:12, 23:3; Luke 11).

## Christianity as a Resource in Healing

Although the Christian patient's faith can be an obstacle in their healing from trauma in the ways outlined above, Christianity also provides a wealth of resources. Consider the words of a patient who describes how his healing from childhood trauma was helped by integrating resources from his faith:

> I often have felt a great deal of comfort in knowing that Jesus, who suffered much, co-suffers with me. That has been important for me in times when I have felt deeply alone. When I could not rely on my family or friends to understand me, I know in some sense that Jesus understands. Jesus looks at me with love, compassion, and a desire to bring comfort and healing to my wounds. Also, it feels critical that there is a power greater than myself aiding me in my recovery. In confronting my abuser, I felt emboldened, knowing who I am in Jesus, and knowing that Jesus is walking with me through this frightening process. There is also something incredible about the way that I do not need to fear bringing all of my emotions to God. I don't feel scared to express anger at Him, or fear, or sadness. I feel like I can be my truest self.

The Bible presents a God who both forgives us and can handle the honest expression of raw and painful emotions. Being able to express these emotions is a critical step in processing and healing from trauma. This is in striking contrast to a performance-oriented Christianity which leads believers to think they must conform to certain behaviors to find acceptance. Large portions of the Bible are a cry to God in the midst of suffering; consider the entire books of Lamentations, Jeremiah, and Job, as well as many Psalms. And most importantly, the suffering of Jesus on the cross, heard in his cry, "My God, my God, why have you forsaken me?" (Mat 27:46, NIV).

The Bible asserts that the purpose of Jesus' death was to reunite humans with the loving God who created them. This vision of reunification is not presented in a sanitized way. The Bible includes descriptions of murder, rape, incest, greed, war, and injustice. It is full of raw, uncensored descriptions of suffering, but also of God's perspective on and response to that suffering. The Bible consistently refers to the role suffering plays in redirecting attention to things of eternal consequence, in building character, and, more mysteriously, in sharing the sufferings of Christ (Phil 3:10, Col 1:24). This framing is a rich resource for Christians trying to reconcile their personal suffering with a loving, omnipotent, and sovereign God.

As discussed in the section on trauma in the Bible, one of the most profound resources for Christians is the knowledge that Christ has suffered and promises to be present with His followers in their suffering (Rom 1:35). Thus, the Christian faith can offer essential co-regulation in the loving presence of God and of the community of believers. Even suffering that is a result of one's own poor choices and behaviors can be a profound lesson about grace and forgiveness, which are at the heart of the Christian message.

## Conclusion

Treating a Christian patient's trauma can be challenging. Not only may there be resistance to accepting the foundational role of the body, specifically the ANS, but belief may be used to justify the typical reluctance to face and process the pain of trauma. However, I have found that working within a Christian's worldview allows patients to draw on valuable resources inherent in their faith. My hope is that any clinician, whether they share the Christian patient's faith or not, would be able to support the traumatized patient's healing both through the patient's faith and through research-validated mental health treatments informed by modern neuroscience.

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# Chapter 7
# Understanding Moral Injury in Individuals: Current Models, Concepts, and Treatments


**Joseph M. Currier, Steven L. Isaak, and Paola Fernandez**

> For I do not understand my own actions. For I do not do what I want, but I do the very thing I hate. Now if I do what I do not want, I agree with the law, that it is good. So now it is no longer I who do it, but sin that dwells within me. For I know that nothing good dwells in me, that is, in my flesh. For I have the desire to do what is right, but not the ability to carry it out. —Romans 7:14–18

## Introduction

The notion that people can be physically, emotionally, and spiritually wounded by their own transgressive behaviors and can suffer as a result of others' transgressions has been affirmed throughout human history in all major religions. Christianity in particular acknowledges the sinfulness of humanity in terms of *who we are* and *what we do*. However, because of Christ's incarnation, death, and resurrection, Christians typically believe they can be pardoned from sin and participate in transformative relationships with a loving God and fellow humans. From a psychological standpoint, Paul's words above capture the inner turmoil that most Christians experience at times in their spiritual journeys. No matter how far we progress in a quest toward virtue, maturity, or sanctification, most Christians will act (or fail to act) in ways that are truly incomprehensible in light of their views about the nature of reality, truth, and God. Rather than always honoring deeply held moral beliefs and values, every Christian will somehow make decisions and act in ways that violate his or her sacred core (i.e., closeness with God). In such moments, we may feel a desire to do what is right but experience an absence of ability, strength, or resolve to do so.

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Thankfully, like Flannery O'Connor's reflections on her own spiritual journey [1], most people contend with a "garden variety" of sins that do not lead to imminent death or serious harm to others (e.g., pride, gluttony, sloth, envy).

Nonetheless, particularly in certain circumstances or professions, peoples' transgressive acts and betrayals of trust may cause a multifaceted condition that psychiatrists, psychologists, and other mental health professionals are calling "moral injury." Although these disciplines have historically minimized moral aspects of trauma and violence, the Old and New Testaments are fraught with examples of moral injury. For example, Deuteronomy 20 highlights the potential inner turmoil of soldiers entering and returning from battle. Psalms also repeatedly affirms the debilitating shame/guilt that may emerge from moral violations which lead to the death or serious harm of another individual (e.g., Psalm 51) or the profound sense of anger/betrayal from being victimized by another's morally transgressive behavior (e.g., Psalm 22). In fact, one might argue that the denouement of salvation history in Christianity, when the many strands of God's redemptive story for humanity were ultimately woven together, began with Christ's morally injurious death on the cross. Drawing upon a case example of moral injury that combines elements from several patients with whom we have worked recently, we aim in this chapter to: (1) define moral injury as a clinical construct, (2) discuss spiritual features of moral injury with special relevance for Christian patients, and (3) summarize emerging treatments for moral injury.

## Case Example

"Bob" was a 21-year-old African American man who was referred for individual therapy by his partner due to apparent posttraumatic stress disorder (PTSD) and depressive symptoms following a motor vehicle accident (MVA) that resulted in serious bodily injury to himself and death of his best friend, "Danny." The MVA had occurred nearly 1 year earlier while Bob and Danny were cutting class from a local community college. Bob asked one of his peers, "James," to give him a ride to a convenience store to get something to drink. James obliged, and both Bob and Danny got into the car. James was eager to show off his driving skills and new car; he drove erratically out of the parking lot, sped up quickly, and began to illegally pass cars on the busy city streets. Soon thereafter, James lost control, and Bob's last memory entailed seeing another vehicle collide with his side of the car. When Bob awoke in an intensive care unit after being unconscious for several hours, he felt an excruciating pain in his lower back and heard Danny crying out in a neighboring bed due to severe abdominal injuries. At the time, Bob reported that all he wanted to do was alleviate his friend's distress, but he surprisingly could not move. Bob suffered from internal bleeding, head trauma, and a spinal cord injury that resulted in temporary paralysis. Over the coming months, Bob recovered from his physical injuries and gradually regained his ability to walk. He also reported invisible injuries that would lead to profound emotional and spiritual suffering. He stated in the

intake interview: "It was my fault. It would have never happened if I hadn't suggested to go get something to drink during school hours."

Following a 6-month period with multiple surgeries and other medical interventions, Danny died from injuries sustained in the MVA. Upon returning to college shortly thereafter, Bob reported an intensification of intrusive recollections and nightmares about the MVA as well as shame/guilt about his role in the event, anger/betrayal at James for driving dangerously, as well as hypervigilance and other indications of chronic hyperarousal that limited his ability to meet academic and social demands (e.g., insomnia, concentration issues). Rumors also circulated in the school that Bob was responsible for Danny's death, which resulted in accusations and death threats that were confusing and scary for him. Combined with a strong desire to avoid any circumstances, relationships, and activities that were somehow reminiscent of the MVA, Bob became increasingly isolated and turned to daily drinking and marijuana use as a way to sooth his inner pain. Soon, he dropped out of school and relied on his partner for provision of basic needs in a manner that worsened his sense of thwarted belongingness and being a burden on others. He agreed to seek treatment at the behest of his partner after voicing a plan to attempt suicide. However, Bob also reported a painful absence of meaning and motivation for pursuing recovery, ultimately stating in the intake interview: "I was the one who deserved to die. I did an unforgiveable thing and do not deserve to be happy or successful. Because of Danny's death, I need to suffer and let God punish me for my selfishness."

## Defining and Conceptualizing Moral Injury

This case illustrates many of the consensus features of moral injury that might warrant focused clinical attention. At present, psychiatry and other mental health professions lack a unifying definition or framework for conceptualizing moral injury. Applying insights from Homer's tragedies (e.g., Achilles in the *Iliad*) to make sense of Vietnam veterans' suffering who were seeking his care as a psychiatrist, Shay [2] first introduced this concept in the mental health literature nearly three decades ago. However, due to a flood of post-9/11 veterans who pursued treatment in the Veterans Healthcare System (VHA) in the mid- to late 2000s, moral injury did not become a target of serious scientific and clinical attention until the publication of Litz and colleagues' [3] seminal article. Since then, moral injury has garnered increasing interest from mental health professionals as well as theologians, philosophers, journalists, and a diversity of other stakeholders. However, even in a single field such as psychiatry, a lack of definitional specificity has created challenges with reliability and communication among clinicians and researchers. Namely, consistent with understanding posttraumatic reactions in general, distinctions should be made between different aspects of this emerging clinical construct (i.e., exposure, appraisal, or outcomes). In an effort to disentangle and define these varying components, Fig. 7.1 presents a preliminary model of the general process by which a moral injury might develop in a patient such as Bob. We will now offer definitions of key

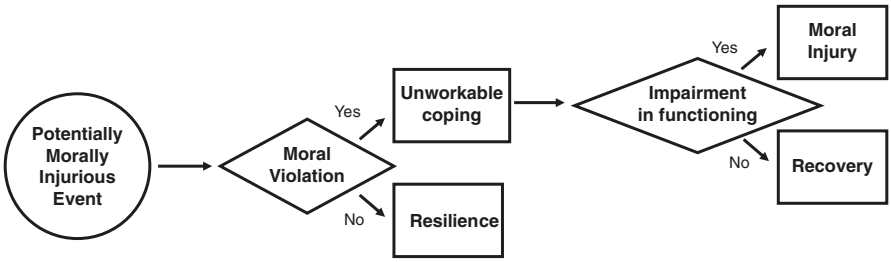


**Fig. 7.1** Model of moral injury development

facets of moral injury development based on contemporary empirical, theoretical, and clinical sources.

***Potentially morally injurious events*** Moral injury is thought to emerge after exposure to severely morally troubling events that fit into two categories according to perceived moral responsibility: transgressive/perpetration-based events and betrayal-based events. First, in keeping with Bob's experience of not being able to compel James to slow down, potentially morally injurious events (PMIEs) may entail actions or decisions in which someone transgresses a moral belief/value by what they did or failed to do. Litz et al. [3] defined these *transgressive acts* and *perpetration-based events* as "perpetrating, failing to prevent, or bearing witness to acts that threaten to transgress deeply held moral beliefs and expectations" (p. 700). As Bob's case also highlights, people might find themselves in the role of a witness or victim of others' moral wrongdoing as well. Shay [2] captured this second category of PMIEs in a three-part definition: (a) betrayal of "what's right," (b) by someone who holds legitimate authority, and (c) in a high-stakes situation. Building on Shay's focus on leadership malpractice and institutional aspects of moral injury, others have expanded these *betrayal-based events* to include other relationships or sources as well (e.g., trusted peers or partners) [4]. When compared to other types of events (e.g., life-threatening events), a growing research base has affirmed that exposures to PMIEs are often linked with greater conditional risk for common mental health conditions after trauma exposure (e.g., PTSD, MDD, suicide ideation or attempts) [3, 4] and greater complexity in distress symptom presentations [5].

***Moral violation*** Notwithstanding the morally challenging nature of PMIEs, we should refrain from pathologizing the occurrence of such stressors in themselves. In the same way that most people who encounter potentially traumatic events in general do not develop chronic PTSD [6], research suggests individuals who experience PMIEs often do not become morally injured (e.g., marines returning from heavy combat operations) [7]. Instead, whether beginning in the aftermath of the event or later in the meaning making process, it is assumed that moral injury only develops when someone has appraised the event as being morally wrong or in violation of deeply held beliefs/values. Furthermore, a person may perceive a sense of personal

agency about the occurrence of PMIEs and/or feel an urge or strong desire to see others' moral violations punished or rectified. For example, Bob believed the MVA had occurred because of his selfishness to grab a soft drink and moral failure in succumbing to peer pressure by not urging James to drive more carefully. In this way, development of moral injury assumes that an individual possesses an intact set of moral beliefs that might be violated in the first place. To date, research has supported the crucial role of appraising PMIEs as being morally wrong in the development of moral injury [8]. However, in itself, the presence of moral violation should not be mistaken for moral injury.

***Unworkable coping*** When PMIEs lead to moral violation, patients will experience painful moral emotions (e.g., shame, guilt, anger) and cognitions (e.g., moral culpability or responsibility, self- or other-condemnation) that can cause significant intrapsychic tension and conflict [9, 10]. Like Bob's response to Danny's untimely and painful death, such emotional-cognitive reactions are usually expected, natural, and non-pathological responses to horrific events. In the same way that people who display indications of distress (e.g., sadness and crying, cognitive confusion, social withdrawal) after losing an attachment figure to bereavement (e.g., child, spouse) often do not display chronic trajectories of PTSD, depression, or other loss-related conditions [6], the presence of moral pain might be an indicator of resilience rather than risk for long-term dysfunction. Namely, moral pain can be essential for maintaining shared moral beliefs/values with others that promote and safeguard the cohesion of human communities [9, 10]. Furthermore, when PMIEs are viewed as morally wrong, these appraisals can prompt behaviors that facilitate healing and repair ties to one's larger social group (e.g., shared acknowledgment of tragedy) as well as re-establish access to culturally and faith-sanctioned pathways to transcendence and belonging in life (e.g., religion, family). Therefore, moral pain may provide adaptive functions for the larger social group, but sometimes at the expense of a given individual such as Bob for varying lengths of time [9, 10]. This pattern can be seen in the ritual of the scapegoat assuming responsibility for the wrongdoing of the larger community in the Old Testament (Exodus 30, Leviticus 16). However, like Bob's extreme isolation and substance abuse, it is primarily when an individual engages in unworkable coping strategies that a moral injury might develop.

***Moral injury*** In many cases, individuals who experience moral violation in response to PMIEs might not cope with painful moral emotions and cognitions in a manner that supports meaning making and social connectedness. Like Bob, they may display a trajectory of chronic emotional and spiritual suffering characterized by impairments in psychosocial functioning, self- or other-condemnation, and a range of self-destructive behaviors. Litz et al. [5] defined moral injury as "disruption in an individual's confidence and expecations about one's own or others' motivation to behave in a just and ethical manner … brought about by perpetrating, failing to prevent, bearing witness to, or learning about acts that trangress deeply held moral beliefs and expectations" (p. 700). Drawing on an acceptance and commitment therapy (ACT) model, Farnsworth et al. [10] defined moral injury as

"expanded and additional psychological, social, and spiritual suffering stemming from costly dysfunctional and/or unworkable attempts to manage, control, or cope with the experience of moral pain" [10]. Although there is a lack of consensus about the specific symptoms or outcomes that may signify this state of being morally injured, perpetration-based moral injury appears to be characterized at least partly by feelings of pervasive shame/guilt; beliefs/attitudes about being unlovable, unforgivable, and incapable of moral decision-making; and self-handicapping behaviors. In cases of betrayal-based events, outcomes of a moral injury likely include feelings of anger and moral disgust, beliefs/attitudes related to mistrust of others, and revenge fantasies for the responsible person(s) [11]. In Bob's case, he presented warning signs of both forms of moral injury. Whereas Bob could not alter the occurrence of the MVA, treatment is needed to address the modifiable ways in which he was carrying the morally injurious event.

Importantly, the model outlined in Fig. 7.1 does not negate the reality of other moral stressors with differing levels of magnitude and impact. Drawing upon a model from Litz and Kerig [12], we see that human beings can encounter *moral challenges* that might cause a sense of frustration but do not affect them directly or lead to much distress or impairment in functioning (e.g., other people's children dying from malnutrition). In more extreme cases, people might contend with *moral stressors* that are more personal but occur less frequently in day-to-day life (e.g., infidelity or deception from spouse). Per Litz and Kerig, these stressors can precipitate moral distress that causes impairment in psychosocial functioning (e.g., rumination, disrupted sleep, depressed mood). However, moral stressors should not be equated with PMIEs in that they are less likely to involve clear threats to personal integrity or loss of life. In these ways, moral stressors are less likely to cause severely painful moral thoughts/emotions that could lead to injurious and scarring experiences. Returning to Bob's case as an example, many college students cut class at times, and a smaller subset might engage in reckless driving. Even in rarer cases when teenagers or young adults get into a non-fatal MVA, they might experience moral frustration or distress based on their own rule-breaking or irresponsible behavior that might prompt introspection, amends-making, and behavior change. However, these situations usually do not end in the type of morally injurious event that Bob experienced [12]. Namely, only a small minority of college students who cut class and/or drive recklessly would truly be able to identify with Bob's experience and profound suffering.

## Christianity and Recovery from Moral Injury

Christianity offers a multitude of behavioral, relational, and psychological dimensions that might inform treatment of moral injury. Since the birth of Christianity over 2000 years ago, a diversity of approaches to prayer and meditation have been passed along from generation to generation (e.g., petitionary, adoration, lament,

centering prayer). In keeping with the theistic relational nature of the Christian faith, engaging in these relationship-maintaining practices can support a sense of closeness with God and provide opportunities to transcend distress, experience positive emotions (peace, joy), and cultivate a fuller awareness of God's loving presence in one's life. As a lifelong Christian, Bob regularly talked with God about his problems, fears, and needs before the MVA. Christian traditions also proscribe unhealthy behaviors that perpetuate and/or worsen suffering in the aftermath of traumatic events. For instance, as highlighted in Bob's case, morally injured persons might turn to substance abuse as a way of anesthetizing moral pain and restoring a fleeting sense of inner equilibrium. Notwithstanding theological diversity within Christianity, Christians have historically refuted dualistic views that downgrade the sacredness of the physical body (e.g., Gnosticism). Like Paul's metaphor of the physical body as a temple of the Holy Spirit (I Corinthians 6:19) or Christ's resurrection as a first fruit of humans' possible bodily restoration after death (I Corinthians 15:20), morally injured persons may imbue healthy lifestyle practices with sacredness in a manner that also facilitates healing and natural recovery processes (e.g., daily exercise, healthy eating).

Christianity can also offer pathways to cultivating horizontal and vertical connections with others that support recovery. From a horizontal view, churches can promote relationships with people from diverse backgrounds who share similar understandings of God, morality, and perceived spiritual realities in the present and future. In such contexts, morally injured persons may receive acceptance, compassion, and support from fellow believers as well as solidarity in pursuing a shared mission together that aligns with the sacred values of the larger group. For example, the valued directions for such a journey could entail pursuing justice and equity in the broader community or being a loving parent or spouse, faithful in work or education, and diligent in practicing spiritual disciplines, as well as valuing other qualities and goals. In turn, horizontal bonds might lessen the probability of loneliness and existential alienation that often forms the core of moral injury. Further, whether via distributing meals, cleaning the facilities, or offering transportation to persons in need, faith communities can also encourage morally injured persons to serve in practical ways that pivot attention away from self and allow them to feel purposeful and productive. In Bob's case, he was born and raised in a Black Protestant church wherein an uncle served as lead pastor and his nuclear and extended family attended regularly. Prior to the MVA, he reportedly "lived in the church" and benefitted deeply from a commitment to serving his faith community in practical ways and receiving support from fellow believers.

Beyond cultivating these horizontal bonds, Christianity also commonly emphasizes the importance of pursuing a vertical connection with God. Relative to adherents of some other religions who are more likely to believe God is an impersonal force [14], Christians traditionally view God as a personal being who desires to establish a close relationship with humans. Dating back to Christ's summary of the Jewish Social-Religious Law (e.g., "You shall love the Lord your God with all your heart and with all your soul and with all your mind," Matthew 22:37) to early theologians (e.g., "To fall in love with God is the greatest romance; to seek Him, the

greatest adventure; to find Him, the greatest human achievement," St. Augustine of Hippo), cultivating both doctrinal and experiential knowledge of God's love can define patients' faith systems. In turn, Christian traditions and communities can offer cultural symbols (e.g., cross) and rituals (e.g., communion) as well as encourage private (e.g., prayer) and communal (e.g., worship service) behaviors that may establish or maintain closeness to God. In keeping with an attachment framework, research on religious coping suggests Christians often turn to God as a safe haven in ways that promote comfort and mitigate risks for unworkable coping strategies [13]. Furthermore, as patients progress in their healing journeys, having a secure attachment to God may provide a robust foundation for exploring the world and pursuing new opportunities and relationships. For example, although school had always been difficult for him and many of his peers had dropped out, Bob's relationship with God fueled a sense of hope to pursue a college degree and career as an FBI agent.

In all of these ways, Christianity offers interpretive frameworks for making meaning of morally injurious events in emotionally and intellectually satisfying ways [14]. Notwithstanding theological and cultural diversity across traditions, Christianity has historically offered robust explanations for trauma that facilitate a sense of coherence, identity, and relative predictability post-trauma (i.e., theodicies). Like Paul's example at the start of the chapter, Christians might then be primed to humbly accept their finitude as fallen or imperfect persons, seek forgiveness and reconciliation, and experience God's solidarity with them in their suffering. In such cases, these transcendent modes of meaning making can reduce shame and limit the counterfactual reasoning and other unhelpful forms of rumination that interfere with recovery from trauma-related disorders. These theodicies can address existential concerns across the mind and heart. For example, Christians have long appealed to Augustine's free will argument in intellectually reconciling the existence of a loving and powerful God with the distressing realities of evil and suffering (i.e., because choosing to love God freely is the highest possible good in life, humans by necessity have freedom to engage in PMIEs). Furthermore, as summarized in the book of Hebrews in particular, Christians often believe that God has cultivated experiential knowledge of evil and suffering via the incarnation, suffering, and death of Christ. In turn, morally injured persons may experience healing from belief in a deity who is intimately familiar with the transgressive acts and betrayals of trust that humans tragically perpetrate against one another.

Notwithstanding these resources for healing, Christianity might also serve as a source of suffering for patients such as Bob. Exline [15] defined spiritual struggles as tensions, strains, and conflicts about matters of ultimate concern that "imply that something in a person's current belief, practice, or experience is causing or perpetuating distress" (p. 459). Per Exline, these struggles might fall into three groups: supernatural, interpersonal, or intrapersonal. First, spiritual struggles may entail distress related to supernatural beings such as emotional tension or disconnection with God or distress related to assigning responsibility to demonic or evil beings. Second, patients could struggle in their relationships with religious adherents or leaders. For instance, morally injured persons might feel judged in their family or

community because of spiritual concerns or struggle with perceived injustice or betrayal at a more macro-level. Third, intrapersonal struggles could emerge from doubting one's beliefs, doctrines, or teachings, or moral distress from not living congruently with perceived standards of perfection, or feeling guilty for violating other sacred beliefs or values that have a basis in one's tradition. In other cases, intrapersonal struggles could be characterized by questions of ultimate meaning about the deeper purpose of human existence or whether there is any order in the universe at all. Overall, research has documented these struggles often co-occur with moral injury [16] and can interfere with recovery from PTSD and other trauma-related conditions in significant ways over time [17].

At the start of treatment, Bob was experiencing several of these spiritual struggles in a manner that added to the severity of his moral injury. Notwithstanding a long-standing routine of attending church and engaging in prayer and spiritual reading, Bob's religious commitment weakened after the MVA, and he felt disconnected from practices that had previously supported healthy coping and well-being. In turn, he received stigmatizing feedback from his family and fellow church members that worsened his shame and sense of moral failure. Like Job's friends, he was accused of "not having enough faith," "losing his way," "being selfish," and "not believing that God was in charge." In addition to feeling betrayed and hurt by fellow believers, Danny's death caused Bob to feel angry and abandoned by God. For the first time in his life, Bob found himself feeling punished by God and questioning God's character and ability to order the universe in a just and loving manner. As a result, Bob felt increasingly distant and ambivalent about his relationship with God and doubted whether the biblical picture of God was truly accurate. Rather than causing others to experience these same struggles, Bob withdrew from his church and family out of a sense of loyalty about not damaging the cohesion of their connections with one another. In so doing, he felt more alone, overwhelmed, and stuck in his moral pain.

## Emerging Psychosocial Treatments for Moral Injury

Currier, Nieuwsma, and Drescher [18] recently developed a book for clinicians that provides guidance for conceptualizing moral injury, addressing clinical issues in assessing and treating moral injury, and describing promising treatments for moral injury. In the absence of a consensus definition and framework for moral injury, patients such as Bob who are struggling to work through painful moral emotions and cognitions associated with morally injurious events need effective treatment. Just as physicians and other healthcare professionals recently needed to implement treatments for COVID-19 in the absence of a vaccine and clinical guidelines that have been subjected to scientific scrutiny and replication, persons who seek psychotherapy should not be delayed care that might promote recovery from moral injury. Returning to Bob's case, failure to address his difficulties in working through shame/guilt and anger/betrayal related to Danny's death would have limited the effectiveness of treatment and likely eventuated in his dropping out. In turn, Bob's

substance abuse, isolation, and functional impairments could have worsened such that suicide became an increasingly viable solution for alleviating his suffering. In many such cases, addressing moral injury in clinical practice can be a life-or-death matter.

When presented with a possible moral injury, clinicians may currently pursue one of the two strategies for planning and selecting treatment. First, just as medical professionals saved lives of COVID-19 patients by applying treatments for related conditions (e.g., malaria), clinicians might implement empirically supported treatments (ESTs) for PTSD in working with patients such as Bob. Namely, many subject experts believe that, unless definitive evidence emerges that these ESTs are inferior to novel approaches that have not been rigorously evaluated, clinicians should rely on treatments with proven safety and efficacy. These approaches are largely based in a cognitive behavioral therapy model, and each has been endorsed by major organizations (e.g., the Institute of Medicine, VHA). For example, cognitive processing therapy (CPT) [19] utilizes cognitive therapy techniques to encourage expression of natural emotions (e.g., sadness), reduce emotions based on unhelpful cognitions (e.g., "I am solely to blame for this event"), and promote a more balanced set of beliefs about self, others, world, and possibly God. In addition, Foa et al.'s prolonged exposure (PE) [20] is another highly supported treatment that utilizes behavioral strategies to emotionally process the traumatic memory and revisit people, places, and activities that are reminiscent of the morally injurious event. Although ACT for PTSD has received less empirical scrutiny to date, this "third-wave" CBT-based intervention has also been applied to moral injury [9]. As opposed to CPT and PE, ACT's goal is not to "feel better" via changing the content of unwanted emotions and thoughts, but rather to increase willingness to experience moral pain for the sake of reconnecting with violated values and responding to life's inevitable stressors in a more psychologically flexible manner.

Other clinical researchers have developed and evaluated novel treatments for morally injured patients. Like Solomon's realization in older adulthood that there is "nothing new under the sun" (Ecclesiastes 1:9), the evolution of psychotherapies over the past century seemingly makes it impossible to create an entirely new approach. Instead, these newer treatments bolster ESTs for PTSD with existing components from other theoretical models (e.g., experiential strategies in emotion-focused therapy [EFT]) [21]. For example, adaptive disclosure (AD) [22] integrates CBT and EFT in a patient-centered manner. In cases of moral injury in which someone is struggling to come to terms with perpetration-based events, AD might begin with imaginal revisiting exercises from PE and shift to imaginal dialogues that specifically address forgiveness issues and moral conflicts. Impact of killing (IOK) [23] also begins with CBT strategies and incorporates elements of EFT and existential and relational psychotherapies. In addition to using exposure and cognitive therapy, IOK integrates experiential and narrative assignments to foster healing and resolution of moral conflicts. Lastly, as highlighted in Bob's case, Building Spiritual Strength (BSS) [24] is designed to foster resolution of spiritual struggles commonly reported among morally injured patients. Developed with an ecumenical and inclusive focus, the goal of BSS is to support patients from diverse faith backgrounds to

resolve spiritual struggles and make more effective use of spiritual resources for restoring a sense of meaning in life and possibly healing a damaged relationship with God.

Following a period of assessment, safety planning, and stabilization, Bob agreed to engage in a treatment approach based largely on AD [22]. Initially, Bob completed sessions in which imaginal exposure was utilized to promote emotional processing of the MVA in the context of a supportive relationship with the clinician. These exercises were recorded, and Bob listened to them between sessions. At points, Bob became emotionally overwhelmed, and the clinician utilized grounding to re-orient him into his body in the present moment. In keeping with a common trajectory in exposure-based treatments, his irritability and intrusive symptoms were worsened at first, and increased anger outbursts outside of sessions created conflicts with his partner. However, Bob maintained open and honest communication with his clinician, and the two of them partnered in adapting the treatment as needed. In the second month of treatment, the clinician utilized in vivo exposure to help Bob become more behaviorally active and connected with his sacred values. Specifically, Bob recognized a deep desire to honor Danny via pursuing hope and faithfulness in the education domain. Rather than continuing to avoid his moral pain, a series of exercises were planned in which Bob reconnected with Danny via visiting the college campus to varying degrees. Initially, he walked around the campus with his partner during non-school hours, and the two of them shared memories of Danny. In turn, Bob gradually moved onto revisiting the campus alone during school hours and worked up to a spiritual ritual of cleaning up the MVA site and planting a cross to affirm his restored confidence in God's atonement, eternal love, and care for his friend. In this process, Bob was able to gradually receive divine forgiveness and repent of substance abuse and other behaviors that were not aligned with his Christian faith system.

In keeping with Greenberg's EFT [21], Bob also engaged in a series of unfinished business imaginal dialogues that deepened his emotional processing of moral pain and ability to grieve Danny's death. For example, roughly halfway into the final imaginal exposure exercise, Bob stopped abruptly and stated: "I don't want to do this anymore." After the clinician inquired what was driving this statement, Bob tearfully stated: "It's my fault." In turn, Bob was coached to invite Danny into the session so that he might share his shame and sense of moral failure. Bob instantly began to sob and started the conversation by saying: "I'm so sorry." This led to Bob voicing his profound remorse for initiating the plan to leave campus, not forcefully insisting on James to slow down, and not being able to reduce his friend's suffering after the MVA. Upon shifting to Danny's chair, Bob recognized his best friend did not blame him for the MVA and experienced Danny's sadness and compassion for him. In turn, Bob gradually began to let go of shame and reconnect with sacred values to honor his friend by engaging more fully in his own life. Next, Bob participated in a dialogue with James. He explained the horrific consequences of his driving and how he felt as a survivor. He expressed feelings of betrayal and anger toward James along with a sense of empathy for how James might be feeling and an accompanying desire to forgive. Lastly, given that Bob voiced indicators of a divine

struggle throughout the treatment, the clinician facilitated a one-chair dialogue with God in which Bob disclosed his sadness, anger, and confusion toward God about Danny's death. After repeatedly switching chairs between himself and his conception of God, Bob began to transform his internalized representation of God from a distant and cruel deity to a co-sufferer who still wanted to forgive and bless him.

## Conclusion

In this chapter, we provided a preliminary model by which a moral injury might develop in individual patients such as Bob, described the double-edged nature of Christianity in aiding and hindering recovery from moral injury, and outlined several of the promising treatments that subject experts have recommended for moral injury. To date, much of the clinical literature on moral injury has focused on military personnel and veterans for the purpose of operationalizing, assessing, and treating this multifaceted construct. As highlighted in Bob's case, moral injury can also provide a helpful framework for conceptualizing the unworkable suffering that sometimes emerges from civilian traumas. For example, as the ongoing COVID-19 pandemic has taught us, we rely heavily on specific professions, such as healthcare workers and first responders, to make decisions and act in ways that sometimes contradict their ideals or sacred beliefs and values. Although findings are limited, there is increasing consensus that moral injury provides a helpful framework for understanding burnout and other occupational hazards of working in healthcare and first responder professions. Looking ahead, there is also a need to equip psychiatrists and other mental health clinicians to address spiritual aspects of moral injury. Notwithstanding progress in introducing medical students and psychiatry residents to the role of spirituality in health [25, 26], trainees in mental health graduate and post-graduate programs generally do not receive any systematic or formalized training in this domain. As such, most mental health clinicians are not equipped to offer the highest quality of care for patients such as Bob. Clinicians certainly should avoid simplistic notions that all Christians will struggle with and/or draw strength from faith and/or spirituality. However, as Bob taught us during the treatment process, culturally responsive care for moral injury requires an acquisition of basic attitudes, knowledge, and skills to plan and facilitate treatment in ways that truly honor the sacred beliefs, values, practices, relationships, and communities of our patients.

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# Chapter 8
# Moral Injury in Christian Organizations: Sacred Moral Injury


**Len Sperry**

## Introduction

When learning about moral injury, I wondered if it might also explain morally injurious actions in Christian settings, particularly clergy sexual abuse. Although moral injury was originally described as a betrayal of trust [1], my clinical experience is that the injury associated with clergy sexual abuse involves much more: a betrayal of "sacred" trust. While there are similarities with moral injury, the causes and effects of sacred betrayal differ considerably. Accordingly, I dub this type "sacred moral injury."

This chapter complements the previous one on moral injury in individuals but focuses on the injury inflicted by ministry personnel in Christian organizations. Those who experience sacred moral injury are many. These include children and youth in Christian schools, aftercare programs, religious education classes, and Christian summer camp as well as altar servers, seminarians, and religious sisters. Similarly, abusers who inflict sacred moral injury can include pastors, priests, youth ministers, teachers, spiritual directors, and bishops. Furthermore, while media coverage focuses largely on clergy sexual abuse in Christian organizations, such abuse is problematic in other religions as well.

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What clinical value might this information have for psychiatrists and other mental health professionals who treat or consult with those who have experienced sexual abuse within a Christian organization? Presumably, they will find the explanation of sacred moral injury and the recovery process clinically useful. Assuming that many of those experiencing sacred moral injury meet the diagnostic criteria for PTSD, standard therapies for that disorder may help to some degree. Unfortunately, those therapies will be insufficient because they fail to deal with spiritual betrayal of trust and the organizational dynamics that foster and reinforce it. Accordingly, referral for those aspects of sacred moral injury may be necessary.

## Moral Distress, Moral Injury, Spiritual Distress, and Spiritual Injury

There are four terms that are similar to and can be confused with sacred moral injury, and this section briefly describes the distinguishing features of moral distress, moral injury, spiritual distress, and spiritual injury.

The term *moral distress* was first described as knowing the right course of action to follow, but organizational constraints make it nearly impossible to pursue [2]. Mental health professionals recognize this type of distress when pressured by superiors to upgrade diagnoses or bill for services not, or only partially, rendered.

Ten years later, Shay [1] coined the term *moral injury* and recently broadened its definition to moral injury as a betrayal of "what's right" either by a person in legitimate authority or by one's self in a high-stakes situation [3]. Both forms of moral injury impair the capacity for trust and increase the risk of despair, suicidality, and interpersonal violence [4]. He calls these two forms "individual responsibility" and "other responsibility." Others have called these "perpetration-based" and "betrayal-based" [5].

Since it was first coined, several descriptions and definitions of moral injury have been offered, yet no consensus definition has emerged [6]. In fact, there is little agreement on at least four considerations. The first is the centrality of an organizational component on which some insist [4, 7], while others do not [8]. The second is that "betrayal of trust" has a central role in some descriptions [6] but not in others [8]. The third is that some accord spiritual distress a central place [6, 9], while others downplay it [10]. The fourth is that moral injury is situated in a military, corporate, or health setting [11], but not in religious organizations [12].

In contrast, all four are characteristic features of sacred moral injury. These are the centrality of an organizational component, the role of betrayal of sacred trust, the necessity of spiritual distress, and a religious context.

## Spiritual Distress, Spiritual Injury, and DSM-5

The context of spiritual moral injury is essential to understanding it. Trauma survivors, including those abused by ministry personnel, inevitably struggle with spiritual issues. They may ask questions like "Why did God allow me to continue to be abused when I prayed for it to stop?" and "What's wrong with me that makes God think that I deserved to be hurt?" These heart-wrenching questions reflect what has come to be known as spiritual distress.

***Spiritual Distress*** Spiritual distress is a term that was introduced in healthcare literature in the 1990s and became a nursing diagnosis [13]. Such distress is defined as "a disruption in the life principle that pervades a person's entire being and that integrates and transcends one's biological and psychological nature" (p. 67). It is usually observed in individuals with health and end-of-life concerns in hospitals and hospices. Common indicators of spiritual distress are anger toward God, spiritual pain, feeling alienated from God, questions about the meaning of life, guilt, despair, and actively seeking pastoral care or spiritual assistance. It should be noted this diagnosis has the same force in nursing, as ICD-9 in medicine and DSM in psychiatry and other mental health disciplines [14].

***Spiritual Injury*** Later a chaplain began using the term "spiritual injury" as basically synonymous with spiritual distress. He defined spiritual injury as a response to an event caused by self, or an event beyond one's control, that damages one's relationship with God, self, and others and alienates the person from that which gives meaning to their life [15]. This definition is the basis of the Berg Spiritual Injury Scale that assesses the degree of distress experienced with eight indicators of spiritual injuries. These are (1) guilt, (2) anger/resentment, (3) sadness/grief, (4) lack of meaning/purpose in life, (5) despair/hopelessness, (6) feeling that life or God has been unfair, (7) worry over religious doubt or disbelief, and (8) fear of death [15, pp. 2–3]. These indicators are similar to those for the nursing diagnosis of spiritual distress. Psychiatrists and other mental health professionals consulting in palliative care settings will recognize spiritual distress and perhaps Berg's indictors of spiritual injury.

***DSM-5*** DSM-5 also addresses spiritual distress in the V-code V62.89, Religious or Spiritual Problems. When the focus of clinical attention involves a spiritual problem, this designation can be used. "Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution" [16, p. 725]. Clearly, this designation extends spiritual distress well beyond a hospital or hospice setting.

In contrast, "sacred moral injury" is a specific type of moral injury that involves elements of spiritual distress and spiritual injury. As visualized in the stacked Venn diagram in Fig. 8.1, sacred moral injury is "seated" within moral injury, indicating


**Fig. 8.1** Relationship of moral injury, spiritual injury, and sacred moral injury

that it shares common features such as betrayal of trust and biopsychosocial factors. It also shares some common features of spiritual injury/spiritual distress such as grief, feeling that God has been unfair, and worry over religious doubt. However, sacred moral injury is also unique in a number of respects.

## Sacred Moral Injury: A Model

Sacred moral injury is described and distinguished from moral injury in this section. This form of injury involves both a personal moral failure and a systemic moral failure. The personal moral failure is by the abuser-betrayer. The systemic moral failure is by the religious organization that is complicit with the abuse. To fully comprehend the concept of sacred moral injury, it is essential to understand that the abuser's immoral behavior is somehow sanctioned or condoned by the religious organization. Figure 8.2 is a systems model, i.e., an input-output model, that emphasizes three key factors: betrayal of sacred trust, sacred moral injury, and reclaiming the sacred. Note that there are the two "inputs": first, as precipitants that result in sacred moral injury and, second, as interventions that can reduce the impact of the injury. Both risk factors and protective factors can significantly influence the severity of this type of injury.

***Betrayal of Sacred Trust*** The experience of betrayal of sacred trust is precipitated by one or more traumatic events. Beyond the betrayal of trust of a military or corporate leader, a parent, or significant other, betrayal of sacred trust represents the

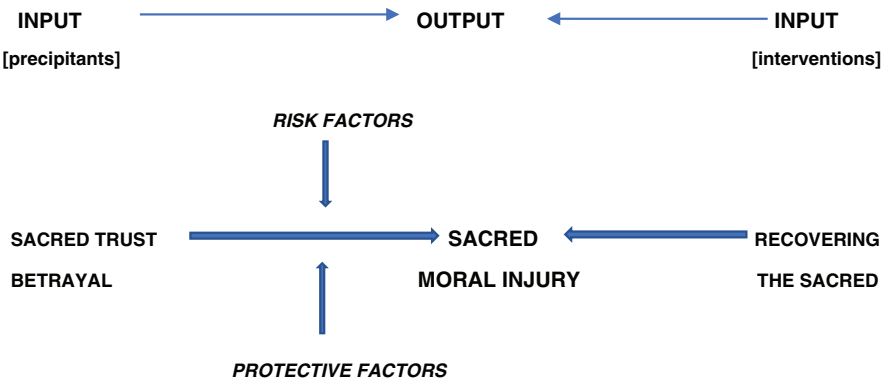


**Fig. 8.2** Sacred moral injury: a systems model

ultimate breach in one's trust in God and God's representative. Accordingly, the abused may reframe their sexual assault by a priest or minister as "God raped me."

***Sacred Moral Injury*** Sacred moral injury is a trauma syndrome with lasting biological, psychological, social, organizational, and spiritual effects which emerges from the experience of betrayal of a sacred trust by a perpetrator of a religious organization whom the victim perceives as representing God. Typically, the religious organization supports the perpetrator by covering up the event and invalidation of the victim. Because it is both an individual moral failure and a system or organizational failure, recovery from it requires that both failures be addressed.

***Recovering the Sacred*** Recovering the sacred is an active process of recovery from the trauma of sacred moral injury that involves regaining trust in God and God's representatives, one's faith, and the sense of sacredness while reducing the short- and long-term bio-psycho-socio-spiritual effects of the betrayal. Because it is more than a medical or psychological condition, therapy, apologies, and compensation are seldom sufficient. For the abused, this process is an extended journey requiring the telling of their story and its acceptance by others, along with necessary and sufficient accountability. Since full reclamation requires that both moral and organizational failures are addressed, offending religious organizations must do more than listen, apologize, and provide therapy and compensation. They must effect changes in strategy, structure, leadership, and culture.

## Protective Factors, Risk Factors, and Severity

Protective factors are those factors that decrease the likelihood of experiencing sacred moral injury. They are the mirror opposite of risk factors which are factors which increase the likelihood of experiencing it. The degree of severity of sacred

moral injury can range from minimal to maximal as is a function of risk factors, protective factors, and other moderating factors.

***Risk Factors*** Several risk factors can foster sacred moral injury. Because attachment style is an important predictor of behavior over the life span, it can increase or decrease the impact of injurious precipitants like the betrayal of sacred trust. Insecure styles, i.e., fearful and dismissive, and particularly the disorganized styles are likely to trigger or exacerbate the injury. Because we postulate that sacred moral injury is trauma-based, it is reasonable to consider the impact of early life trauma as a risk factor for this form of moral injury. The 10-item ACE (adverse childhood experiences) instrument is used by psychiatrists and other mental health providers to screen adults for childhood trauma. Based on ACE scores, those who experienced four or more indicators of adverse childhood exposure have 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempts. Furthermore, they have a two- to fourfold increase in smoking and significantly more health conditions in midlife such as heart disease, chronic lung disease, and cancer compared to those with no indicators [17].

Low socioeconomic status and low education level along with limited family support and other social support are common risk factors. Shame proneness is another. We have found that those abused often had negative God representations. These include representations that are also called images of God that are uncaring, overly demanding, vengeful, or distant. A recent meta-analysis suggests that God representations are more useful indicators of psychological functioning and well-being than other religious or spiritual indicators [18].

***Protective Factors*** In contrast, there are several protective factors that are likely to insulate or reduce the impact of sacred moral injury. These include secure attachment styles and few, if any, adverse childhood experiences, a reflection of resiliency. Research on protective factors in moral injury suggests that high self-esteem and the capacity for self-forgiveness [8] might also be protective in sacred moral injury. High levels of family support and other social support are also likely to be protective. Similarly, holding the just world belief has been identified as a protective factor in moral injury [8] and likely to also be for sacred moral injury. We have also observed that those abused by ministry personnel with more positive God representations, such as being caring, loving, and merciful, tend to have a milder form of sacred moral injury [18].

***Severity*** The degree of severity is related both to the victim's overall vulnerability and resilience and to factors such as the relational proximity of the victim to the perpetrator, e.g., if the perpetrator has befriended the family of an intended victim. Moderating factors include the extent to which others in the religious setting "shield" the abused or "facilitate" the abuser's actions. Shielding behaviors include warning potential victims, reporting early warning signs of abuse, and advocating for abuse prevention policies and procedure. Facilitating behaviors include failure to stop present or future injurious behavior, by "keeping the secret" and by "protecting" the reputation and resources of the organization rather than helping the abused.

## Organizational and Systems Dynamics

Organizational and systems dynamics reveal how an organization functions and dysfunctions [19]. Psychiatrists and psychologists who understand organizational dynamics can more effectively consult with individuals presenting with sacred moral injury and related concerns. Knowledge of four of an organization's subsystems is critical in evaluating and changing it. They are strategy, structure, leadership, and culture [20, 21].

*Strategy* is the overall plan or course of action for achieving its mission and goals. Whereas mission specifies "what will be done," strategy specifies "how it will be done." The organization's core values inform strategy and ongoing assessment of the extent to which these stated values match the actual values of the organization and are most useful indicators of its health. For example, sacred moral injury seldom occurs when a religious organization's core values are consistently practiced. *Structure* involves the mechanisms – its roles, reporting relationships, policies and procedures, and reward and sanction systems – that assist the organization in achieving its intended mission and goals. *Leadership* is the process of inspiring, guiding, and coordinating members of the organization to achieve the mission and goals of the corporation. *Culture* is the constellation of shared experiences, beliefs, assumptions, stories, customs, and actions that characterize the organization. It defines the organization's identity to those inside and outside the organization. Specifically, clerical culture is reflective of many religious organizations, while clericalism is a toxic form of it. Some organizational cultures actually foster and reward clerical or other ministerial misbehavior [19].

All of these four subsystems are interconnected and self-reinforcing. Not surprisingly, it becomes very challenging and difficult for an organization to root out and change these subsystems. In our experience, clericalism (an aspect of culture) is common in cases of sacred moral injury, particularly when privilege, secrecy, and the expectation to protect the organization's reputation and resources are its core values (strategy). Religious leaders may engage in downplaying or covering up such injurious behaviors (leadership) and intentionally or unintentionally reward the misbehavior (structure) as they endeavor to protect the institution. This may result in "promoting" a perpetrator to a pastorate or granting them medical or study leave or in negotiating a lowball offer of compensation to a victim rather than foster reclaiming of the sacred for him or her (leadership, culture, strategy, and structure) [21].

Finally, a not uncommon leadership tactic in organizations that foster such misconduct is reliance on the "excuse factor." Superiors and others in the organization will characterize ministerial misconduct as "just a psychological problem." They may use words like "he's just a bad apple" when the reality is that the "barrel is rotten." This excuse exonerates the organization from blame, responsibility, and the need to change. It protects the organization which further reinforces its dynamics. The upshot is that the religious organization can send abusers for treatment or reassign them but evade the prospect of changing its problematic organizational dynamics.

## Recovering the Sacred

Here is a recap of the preceding text. An abbreviated version of Fig. 8.1 is sacred betrayal → sacred moral injury → recovering the sacred. Sacred moral injury arises from two sources. The first source is the perpetrator whose abuse activates sacred betrayal which is compounded by the perpetrator's threats and invalidation of the abused. The more the perpetrator is perceived as God's representative, the greater the level of sacred betrayal, and the more extensive the experience of sacred moral injury. The result is not just the loss of innocence; it is also the loss of both faith and a very deep sense of the sacred.

The second source of sacred moral injury is the systemic factors that not only facilitate the abuse but also protect the perpetrator and the organization. The culture of such an organization tends to reward secrecy and loyalty above transparency and accountability. Accordingly, abuse is covered up, perpetrators are reassigned, and the abused who come forward face a "reconciliation" process in which they may receive limited care and recompense and at worst are re-traumatized or become suicidal.

The experience of recovering the sacred must address both of these sources: individual and systemic. At the individual level, the abused will experience healing which begins with having their story listened and responded to with acknowledgment as well as validation of their sense of personal worth and spiritual worth. This means reversing the helplessness and powerlessness of sacred betrayed [24]. At the organizational level, there will be a shift to a healthier culture of safety, healing, transparency, and accountability. Such change will be apparent in leadership, along with policies and procedures that facilitate healing. Hopefully, the outcome is regaining trust in God and God's representatives, with a rekindled faith and a sense of the sacred.

## The Process of Recovering the Sacred

A five-step process characterizes recovery: (1) empathically listening to the abused person's story, acknowledgment, and validation; (2) apology and forgiveness; (3) therapy; (4) compensation; and (5) organizational or systemic change. It is not necessary that these steps follow in this order. For example, the abused may begin with therapy before encountering the offending organization. To the extent that all five steps are included, the more likely a full recovery will be achieved. Each of these steps is described here.

Diocese and religious orders typically have a victims' assistance coordinator who serves as the first point of contact with the abused. Other personnel will be involved as the healing process unfolds. What follows is how the abused individual is likely to experience these steps in a reasonably healthy diocese or religious order.

The case of Danny realistically illustrates this process of recovery. It is realistic because for too many abused individuals, not all steps – or only some aspects of a step – are implemented. The more that all or most steps are involved, the fuller the recovery of the sacred and the resolution of the biological, psychological, social, spiritual, and systemic consequences.

## *Danny*

Danny was abused by the pastor of his parish 20 years prior to his face-to-face meeting with Rev. Joseph Guido, a priest he did not know. Danny asked to meet him to discuss an important matter [12]. They met in a coffee shop and Danny told him his story. While in eighth grade of the parish school, he was told the pastor wanted him in the rectory. Obediently, he stood still as the priest groped Danny's buttocks and genitalia and then masturbated in front of Danny. This abuse continued over months on church property. Later as an adult, Danny began therapy and sued the diocese for compensation for the abuse. Yet, he felt compelled to talk to a priest and tell his story. Despite a gnawing sense of hurt, insomnia, and a recurrent dream of running, Danny reported doing reasonably well as a husband and coworker. The two talked for nearly 2 hours and never saw each other again.

Danny's story reflects key features of sexual abuse perpetrated by Christian ministers. It was devastating psychologically and spiritually for Danny. "It is evident that Danny lost not only his innocence but also his faith, his sense of the sacred and of sanctuary. We will not have served him and others like him well if we offer only care, recompense, and protection (important as each may be) and we do not aid in the restoration of the sacred" [22, p. 2].

Years later Guido read Danny's obituary. He wondered if his death by cancer at age 39 was related to sexual abuse. Danny was buried by his family and friends in a Christian, but not Catholic, church [12].

## *Listening, Acknowledgment, and Validation*

Sacred betrayal is compounded by the perpetrator's threats and invalidation of the abused and often accompanied by a lack of empathy and unwillingness to listen to the abused person's suffering by other members of the offending organization [23]. Not surprisingly, listening, acknowledgment, and validation are essential to healing and recovery. It may well be that failure to listen and validate may exacerbate the experience of sacred betrayal.

During an initial meeting with the victim assistance coordinator, abused individuals are given the opportunity to tell their story. Thereafter, the coordinator or designee acknowledges the pain and psychological and spiritual suffering. It is essential that the abused individual's worth as a person and as a child of God be

affirmed and validated. This first interaction should be as supportive as possible. This engenders a positive rapport which is essential for the other steps to proceed. Because some individuals wait decades to disclose their abuse, it is important that they feel supported when they do tell their story. If they do not feel supported or, worse, are criticized or made to feel guilty, they may retreat into silence again or be re-traumatized.

While Danny's recovery began with therapy and seeking compensation, he came to realize that something was missing. He needed a representative of the Church to hear and acknowledge his story. The representative he chose, Father Guido, listened and acknowledged Danny's story. Presumably, he also validated Danny's worth as a person and as a Christian.

## *Apology and Forgiveness*

While apology is commonly used synonymously with forgiveness, the two differ considerably. Research indicates that apology is most effective when it originates from the needs and the perspective of the abused rather than from the needs and the perspectives of the betrayer and their organization [24]. In other words, a meaningful apology is accompanied by amends. While Christian leaders have apologized for the abuse of their clergy, many abused persons do not find these apologies meaningful because making amends would mean a commitment to change the system that supports sacred betrayal. Nevertheless, hearing an apology from the betraying institution or its representative can greatly facilitate the process of recovery [24].

Forgiveness of others, also known as interpersonal forgiveness [25], is a central tenet of Christianity and other religions. However, there are two other types of forgiveness, divine forgiveness and self-forgiveness [26]. While most research has emphasized interpersonal forgiveness, recent research on divine forgiveness and self-forgiveness seems pertinent to recovery of the sacred. In short, having the feeling that one is forgiven by God makes it more likely that an individual will be more self-forgiving. Presumably, when one experiences both divine forgiveness and self-forgiveness, interpersonal forgiveness will be easier [26].

All three types of forgiveness are necessary for a full recovery of the sacred. Because the abused tend to perceive the abuser as God's representative, they blame God for allowing the abuse. Also, the extent to which they believe they may have somehow brought on the abuse by their dress, actions, or not being holy enough can make them feel guilty. Accordingly, experiencing divine forgiveness is significant in the healing and recovery process. Self-forgiveness tends to be very difficult unless they experience a sense of both forgiving and being forgiven by God. Having the assistance of a trusted and experienced individual to facilitate these three types of forgiveness is usually necessary.

Finally, apologies and forgiveness are best viewed as processes rather than as events [24]. Apologies are not necessary for forgiveness and often seem to be

insufficient to the abused. All too often the rights of the betrayer and the institutions have been primary, and addressing those issues is the focus of the public relations efforts of these organizations. As one engages in an interpersonal process of forgiveness, the addition of apology statements can assist the healing process.

The victim assistance coordinator or designee continues to listen attentively and can respond by apologizing in the name of the diocese or religious order for the abuse. Then, the matter of forgiveness in all three spheres is facilitated with other personnel. In some settings and situations, the abusing priest may be involved in the process of interpersonal forgiveness.

There is no indication that apology and forgiveness were part of Danny's pastoral encounter with Father Guido. However, another Christian minister might have facilitated these processes afterward.

## *Therapy*

Sacred moral injury, like moral injury, is a traumatic condition and is appropriately treated with trauma-focused therapy. The terms trauma-focused therapy and trauma-informed therapy are often used synonymously. These therapies recognize the role of trauma in the outlook, emotions, and behavior of those with a trauma history. Accordingly, they address the impact of trauma on life experiences and relationships.

Because sacred moral injury is more than a psychological condition, its resolution requires addressing the spiritual domain. Currently, Spiritually Integrated Cognitive Processing Therapy (SICPT) is an evidence-based treatment for moral injury in the setting of PTSD [27] that addresses, to some degree, that domain. SICPT is a relatively new treatment [27, 28] that targets moral injury and incorporates both psychological and spiritual resources when treating military personnel. Adapted from Cognitive Processing Therapy, SICPT addresses the spiritual struggles and ramifications of trauma and their interconnection with PTSD symptoms. While other therapeutic approaches address spirituality in the treatment of PTSD, moral injury is unlikely to be addressed. Thus, SICPT offers considerably more than other approaches. However, SICPT does not focus on key targets in recovery of the sacred, i.e., spiritual confusion, loss of the sense of the scared [29], and sacred betrayal of trust. Again, because sacred moral injury is both a failure of the individual perpetrator and of organizational dynamics, recovery of the sacred requires that both the psychological and the organizational be addressed.

Reportedly, Danny engaged in some form of psychotherapy which apparently helped to some degree [12]. While it is a necessary intervention for most who are sexually abused by clergy, therapy itself is not a sufficient intervention for recovering the sacred.

## *Compensation*

Most dioceses and religious orders provide financial compensation for sexual abuse as a result of a lawsuit or an out-of-court settlement. Too often, such compensation, which may include therapy costs, is the only way they respond to those abused by clergy. Formal programs called reconciliation and compensation programs (RCP) are currently operative in some dioceses and religious orders [30]. Compensation is paid on the condition that the Christian organization will not be sued and that a non-disclosure agreement is signed. RCP is not intended to address matters of listening, acknowledgment, apology, forgiveness, nor the psychological, spiritual, and organizational dimensions associated with sacred moral injury.

Although monetary compensation was received by Danny, it was not sufficient in his reclaiming of the sacred.

## *Organizational-Systemic Change*

Previously, the subsystems of an organization were described. Three are highlighted here: structure, culture, and leadership. In reasonably healthy dioceses and religious orders, it is not unreasonable to find some degree of systemic changes in at least these three subsystems. For example, a diocese or religious order will have implemented policies and procedures that foster restoration of the sacred for the abused. Such policies are likely to be clear, transparent, and fair with regard to compensation and the therapy provided (structure). They are focused on restorative rather than retributive justice. The diocese or religious order has developed and maintained a culture of transparency. Equally important is a culture that fosters trauma-informed care. Of particular importance is the function of the victims' assistance coordinator or designee who is expected to establish a welcoming, healing, and supportive environment with the abused. By their words and actions, the coordinator can foster healing and reconciliation, and not re-traumatize the abused. The coordinator or designee is able to (1) provide referrals for therapy with trained and effective trauma-informed therapists; (2) coordinate with appropriate diocesan or religious order personnel that can foster the listening-acknowledgment-validation, apology, and forgiveness processes; and (3) explain the compensation process (leadership). In less healthy Christian organizations, even small systemic changes can be preventive.

There is no indication that systemic changes were operative in Danny's recovery process. While Danny did experience three of these five steps, there is no indication that apology and forgiveness, nor organizational and systemic change, were involved. Had he experienced all five steps fully, one might speculate that this might end his painful struggle and allow his return to the Catholic church. This might have also lessened his insomnia and recurrent dreams and perhaps allowed him to not succumb to cancer before reaching the age of 40.

## Sacred Moral Injury in Other Religions

Ongoing media coverage has portrayed clergy sexual abuse of children as more common in Christian – particularly Catholic – organizations than in Jewish, Hindu, or Muslim organizations. In addition to influencing public opinion about the extent of the problem, this coverage has fostered the assumption that there is something inherent in Catholicism itself, e.g., celibacy, or its organizational dynamics, that somehow causes or accounts for this apparent prevalence. While comparative research on sexual abuse by clergy across religions is in its infancy, there are some notable findings that bear consideration.

Chief among these is that Jewish rabbis, Buddhist monks, Hindu gurus, and Muslim imams also perpetrate sacred moral injury and that it is similar to that perpetrated by Christian clergy: abusers are perceived by their communities as representatives of God, and those abused feel betrayed by their religious leaders and institutions [31]. Regarding the assumption that celibacy is a cause of sexual abuse by Catholic priests, research suggests "that due to the dominance of Protestants amongst the American population, a negative opinion had persisted against clerical celibacy within the Catholic Church and that this had become connected to cCSA [clergy child sexual abuse]" [31, pp. 574–575]. It concludes that the "mainstream media was ignoring larger numbers of [abuse] in the Protestant denominations, partly to criticize celibacy" [31, p. 575]. Furthermore, it was found that organizational structure, culture, and leadership dynamics foster and reinforce such abuse across all religions and denial, silence, and the sheltering of clergy abusers are common in all religious organizations [31]. Not surprisingly, a 2019 national survey by Pew Research Center found that 48% of those surveyed believed that clerical sexual abuse was unique to clergy and leaders in the Catholic Church, while 47% believed it was equally common among clergy and leaders in other religions [32]. Accordingly, it would not be unreasonable to conclude that media reports, public opinion, and assumptions that clergy sexual abuse is inherent to Catholicism are questionable.

Clearly, more research and critical examination of the phenomenon of clergy sexual abuse is needed across all denominations and religions. Comparative studies are essential in determining the actual prevalence and nature of this form of moral injury as well as the organizational responses and safeguarding measures necessary to prevent such abuse.

## Role of the Mental Health Professionals

How might the information in this chapter be useful to mental health professionals or consultants working with someone characterized by spiritual moral injury? For licensed mental health professionals who are ordained ministers or certified in pastoral counseling, working with such patients might well be within their scope of professional practice. Without such training, working with such patients on

restoration of the sacred – steps 1, 2, 4, and 5 – may be beyond their training. Mental health professionals can provide or refer for trauma-focused therapy – step 3. Nevertheless, these professionals can also refer the patient to an appropriate representative of their Christian organization, i.e., a victim assistance coordinator, who can facilitate steps 1, 2, and 4. Consultation on organizational changes, step 5, may also be advisable.

## Conclusion

Sacred moral injury is a form of moral injury. While sharing some features with moral injury, there are clear differences in defining, resolving, and preventing sacred moral injury. Key differences are the centrality of organizational dynamics, the role of sacred betrayal of trust, the necessity of spiritual distress, and a religious context. Since it is more than a psychological condition, the usual remedies – therapy, apologies, and compensation – are necessary but not sufficient. Rather, the process of recovering the sacred involves regaining trust in God and God's representatives and the sense of sacredness while reducing the short- and long-term bio-psycho-socio-spiritual effects of the betrayal.

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# Chapter 9
# Christianity and Disability


**John Swinton and Erin Raffety**

## Introduction

*When my daughter*[1] *was approximately 4 months old, our pediatrician noticed her head was not growing. She suggested that my spouse and I take her to the hospital to see a pediatric neurologist. Our daughter had been increasingly irritable and uncomfortable for months, crying incessantly and vomiting violently. Our friends and family tried to reassure us, even after we were instructed to see the pediatric neurologist, that everything would be fine. Several of them told us of friends whose babies grew out of such discomfort and pain to be perfectly "normal." When we got to the hospital that afternoon, the pediatric neurologist did see cause for concern, so she ordered a few tests, and we waited for the results. She must have seen the worry on our faces. "No matter what happens," she said, looking deep into our eyes, "the baby you brought to the hospital today is still the same baby you're taking home. Nothing about that has changed."*

*Almost a year later, our daughter was diagnosed with a terminal, degenerative disease of the brain. Today, at age 6, she is multiply disabled and medically complex, relying on a feeding tube for nutrition, a wheelchair for mobility, and her caregivers for communication. But that description doesn't tell you all that*

[1] The opening two paragraphs of this introduction are written in first person to convey the co-author's experience, heretofore referred to as ER (Erin Raffety).

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*much about who she is to us and to her family and friends or, perhaps especially, who she is in relationship with God. This is why I have thought of the words of that neurologist countless times since that first appointment of many at the hospital: her words acknowledged that whatever uncertainty was present, the value of my daughter's life, disabled or otherwise, was not at stake. Such conviction helped me accept and receive my daughter as she was and trust that God was also active in loving and accompanying our family toward hope and flourishing.*

We begin with this story because it brings to the fore some of the key issues that we will discuss in this chapter. Disability is complex, confusing, and sometimes difficult. But above all else, it is personal. It is something that happens within the lives of unique individuals who seek to discover meaning, purpose, hope, and joy in the midst of sometimes difficult circumstances. The doctor's response to ER's situation reveals something of what it looks like when clinicians grasp the full breadth of a situation and respond in ways that are fully informed and deeply compassionate. Our focus here will be on the Christian tradition, what it might bring to our understanding of disability and how best to respond. Disability and mental health challenges may raise doubts for patients and their families about where God is, what God is doing, and how God is working in their midst. But when physicians recognize these doubts and help families face them (rather than shying away from them), they can help patients and families make sense of their experiences not just physically or emotionally but also spiritually and theologically.

Clearly, this chapter cannot do justice to the breadth and depth of biblical and theological scholarship on the topic of Christianity and disability or the myriad of practices and ways that Christians engage with experiences of disability. However, with healthcare providers, patients, and family members in mind, this chapter introduces some key theological, biblical, and practical frameworks from which Christians have considered disability, namely, those of *theodicy*, *value*, *creation*, *healing*, *personhood*, and *human flourishing*. By moving practically and topically, the chapter does not offer a comprehensive theology of disability but rather introduces themes and perspectives that families and patients may reference, utilize, or find helpful in constructing their own theological interpretations of their experiences with disability and mental health challenges.

The chapter also adopts a critical point of view with respect to the way Christian tradition and biblical interpretation have marginalized and discriminated against people with disabilities on the basis of presumed bodily or mental deficiencies. Instead, using practical questions to uplift the tenets of the Christian faith and the Christian God, this chapter offers practitioners a basic Trinitarian reorientation to disability and points toward God as the author of *all* life as Creator, Redeemer, and Sustainer. By pointing readers back to God's loving and gracious work in the world, we emphasize Jesus's investment in the personhood of disabled persons and the Spirit's equipping for flourishing in a diversity of human forms.

## Asking Big Questions

For human beings, the fear of the unknown naturally introduces doubt and distress. Because many humans do not necessarily experience disability themselves (the World Health Organization estimates that 20 percent of people in the world live with a disability), the diagnosis or the experience of disability may raise questions or concerns, especially about life or quality of life in the future. Furthermore, in modernity, disability has frequently been primarily addressed and interpreted through a medical framework that has framed disability as a malfunction or defect of the body that needs to be treated, rehabilitated, and/or cured [1, 2]. This meaning of disability is so pervasive that families and patients may not even recognize its ubiquity in their daily lives. For example, the perception that there was something "wrong" with ER's child to begin with came from scientific norms of growth and development that placed the growth of her head circumference below average. By taking their child to the pediatric neurologist, ER and her husband assumed medicine's authority to interpret and alleviate the child's suffering and pain.

It is therefore important for both medical practitioners and Christians more generally to recognize the cultural power of medicine, especially in the modern world, and how its norms and values have often reinforced a perception of disability as tragedy. Beginning with the assumption that disability is tragic, avoidable, and inevitably bad invites theological explanations that perceive it as an evil or a punishment, for which God may be responsible, or, at the very least, may need to provide explanation. However, letting contemporary cultural perceptions of disability drive the theological conversation around disability fails to take seriously what it ultimately means to be a Christian, that is, *to take God as the starting point for all of our understandings about human life* and indeed the meaning of life itself.

Those who belong to the Christian faith should be encouraged to pursue ultimate questions, perhaps especially about disability, through the lens of faith and their experiences of God and others [3]. None of this, of course, is intended to downgrade the importance of medicine. Quite the opposite, medicine is a vital source of healing for all people. Our challenge, however, is to identify and critique that certain ways of looking that emerge from medicine can be negative and misleading in terms of disability. With these provisional thoughts and insights in mind, we must begin with a basic question: *what exactly do we mean when we talk about disability?*

## What Is Disability?

For the purposes of this chapter, we will work with the following definition of disability: *a physical or psychological impairment that affects a person's interaction with society*. There are two dimensions to this definition that we should draw attention to. First is the term *impairment*. There is a distinction between disability and impairment. An *impairment* is the particular form of difference that a person has,

such as blindness, deafness, mobility issues, or mental health challenges. These may require that an individual needs certain forms of help and intervention, but often the *disabling* dimensions of their conditions lie also in the social environment [4, 5]. For example, people in wheelchairs are often disabled by the built environment that is designed in a way that privileges those who are not in wheelchairs. A person with an intellectual disability may be disabled by an overemphasis on intellect and reason within wider society. For instance, if we privileged community, love, and relationships over intellectual ability, this particular form of impairment would not be disabling [6].

People with mental health challenges are often deeply disabled by forms of stigma that reduce them to stereotypes and caricatures. For instance, for the person who hears voices, there is evidence that voice hearing is not necessarily disabling [7]. A significant number of people without psychiatric diagnosis live with voices that others do not hear without any significant distress. Voice hearing becomes problematic when it causes distress to individuals and their communities [7, 8]. However, hearing voices also becomes disabling when people make negative associations in relation to the person who experiences those voices that may not be true. It can thus be seen that a *disability* emerges from the ways in which any given form of impairment interacts with society in a manner that prevents or inhibits the well-being of the individual who bears the impairment. Therefore, disability is a *social construct*, not in the sense that it is not real or doesn't have physical or psychological causes but in the sense that it is something that society builds on top of impairments, often in a negative way.

A second dimension of this definition emerges from the fact that in modernity, there has been a tendency to regard disability primarily as a physical abnormality or psychological pathology that is best assessed and treated by medicine [9]. Within this *medical model*, disability is seen as something to be cured, healed, or mended, primarily by medical professionals or rehabilitation services. As mentioned, we have no objections to the use of medicine to help ease distress or pain. When medicine helps us to see that "The baby you brought to the hospital today is still the same baby you're taking home. Nothing about that has changed," it can be a tremendous source of goodness. But if it only draws our attention to our broken parts, we end up with an incomplete way of helping individuals make meaning, sense, and hope for the future. The danger with an overly medicalized approach is that it frames disability primarily as a negative thing: a problem to be solved rather than a meaningful and good life to be lived. In our definition and in what follows, we will utilize both of these models – the social model and the medical model – to develop an understanding of the interface between theology, scripture, practice, and disability.

## Insights from Christian Theology

Alongside scripture (which we will review in the next section), Christian theology has also offered vital insights into the nature of impairment and disability [10]. It is helpful to reflect on this in terms of Trinitarian theology. The bedrock of the

Christian faith is a belief in a God who is not merely Creator (some would say Father) but also Redeemer (in the person of Jesus Christ) and Sustainer (as the Holy Spirit). Importantly, this Trinitarian framework identifies not only who God is but also what God's relationship is with God's people. God creates the world and it is good. Genesis 1:26–28 informs us that *all* human beings are created in the image of God. So, the goodness of creation and the desire for God to lovingly relate specifically with humans form the overarching foundation of the biblical narrative. It is clear that God delights in *all* human beings.

All of this is fine in theory! However, during times of fear and uncertainty, people are rarely comforted simply by knowledge about who God is. They need to feel the presence of God in the very face of fear and suffering. Theological ideas require embodiment for them to be convincing. When practitioners assure parents and patients, like ER's neurologist did, that even in the face of change, relationships between human beings are ultimately meaningful and good, they harken back to the goodness of creation. Such goodness precedes fear, heartache, or pain and helps to invoke feelings of the presence of a God who is in the business of redeeming and sustaining all that God creates in love (1 John 4:18). As we will see, scripture attests to the fact that people with disabilities, be they physical or psychological, are created in the image of God and that they are good, loved, and loveable. This is a message that is too often undermined by the problem-solving modes that can come from forms of science and medicine when people forget about the importance of the *person* before them. Such a creation-oriented perspective is an important corollary to the important diagnostic and practical treatments that medicine can provide to enhance the lives of people with disabilities.

In the Christian Gospels, Jesus is pictured socializing with outcasts in society, especially people who were poor and oppressed, and He is sometimes noted as having a preferential option for the "poor." Indeed, much of Jesus's teaching and preaching champions countercultural values like weakness and humility and conjures a new kingdom in which justice brings liberation to those who are oppressed, notably including persons with disabilities. But it is vital to remember that all persons in Jesus's ministry receive their worth not on the basis of rights or achievement, but on the basis of belonging to God and to God's kingdom. Thus, the radicality of the Christian message is that none of us, persons with disabilities or persons without disabilities, are loved because of what we do or even because of who we are but because of who we are in Christ. In fact, in Jesus, each of us receives a new identity; by grace not by works, we receive salvation and life everlasting; and the Spirit works in our lives on earth in mysterious ways.

This quintessential Gospel teaching reminds practitioners and Christians that to ask questions about how Christians think of people with disabilities is to ask how God thinks about people in general. And one striking example that may resonate with people with disabilities is that in Jesus's very central act of becoming human like us, and being crucified on the cross, Jesus not only suffers with human beings but is risen with a body that bears scars and wounds as evidence of His resurrection (Luke 24:39). In 1995, Nancy Eiesland wrote that Jesus is "the disabled God," the ultimate symbol that people with disabilities' bodies and lives are valid and meaningful to both God and the greater witness of Christians, the body of Christ [11].

Much contemporary theological scholarship foregrounds the gifts of vulnerability, friendship, and discipleship in Jesus's ministry with people with disabilities [6, 12, 13]. Contemporary theologians study disability and persons with disabilities not as outliers, but as people whose embodied experiences lend insight into both the human condition and the Christian life. Many theologians focus on sacraments such as baptism and communion, because it is here that many people with disabilities have been practically excluded from participation, membership, or belonging to the broader body of Christ on the basis of presumed mental capacity or physical deficiency. Even though prevailing theologies emphasize the mystery and wisdom of the Spirit in the sacraments [14] and the equipping of disabled persons for ministry, flourishing, and leadership [15–17], the widespread exclusion of persons with disabilities from congregational life due to inaccessible architecture, liturgies, and attitudes is a profound, practical reality [18, 19].

As we shall see in the next section, the interpretation of scriptures, particularly the healing narratives, has posed challenges for people with disabilities in Christian life. Given the variety of experiences of people with disabilities with respect to the Christian tradition, it is important for medical practitioners not to make assumptions about how Christian theology operates for Christian patients and families. Yet, understanding that the Christian tradition is grounded in the creation, redemption, and sustaining of the Triune God, practitioners do well to remember that experiences with Christians and the Church may not always be reflective of who God is and how God acts with respect to disabled persons.

## Disability and the Bible

Central to the Christian tradition is the Bible. It is within the narratives, poems, songs of hope, and cries of lamentation that Christians discover what it means and what it feels like to encounter and live with God. Unfortunately, the Bible has not always represented Good News to people with disabilities. Christians have struggled to use the Bible faithfully to interpret disability, often pigeon-holing people into purity texts in the Old Testament or the healing narratives in the New Testament. Some texts have even been described as "texts of terror" by people with disabilities, due to the fact that they have been interpreted by clergy and congregants to presume that there is something wrong with disabled bodies and that fixing this perceived brokenness is what the church should be doing [20]. This, of course, serves to further marginalize people with disabilities and anchor disabled persons' need for healing and repentance at the center of church ministry. What we can easily end up with is a spiritualized version of the medical model wherein the dynamic of identifying bad spots in people and then using prayer to eradicate them closes us off from the more subtle nuances of healing that we find in scripture [21].

Within the realm of mental health, the unconventional experiences of schizophrenia, the highs and lows of bipolar disorder, and the obsessive focus of individuals on small things easily feed into a hermeneutic that assumes that these things are

the product of sin, if not indeed the work of the devil himself! This is unspeakably painful for people. How might it feel to be going through deeply troubling experiences and for your friends and fellow Christians to say that either it's your own fault or that the devil is somehow living within you? We might describe this kind of response as *casual theodicy.* Casual theodicy is like casual racism. Casual racism is unthinking racial prejudice that just pops up unnoticed in our everyday conversation: "I don't know what you are complaining about. I have to spend hours in the sun to get a tan like yours!" Casual theodicy, theodicy being the human attempt to understand why God allows suffering, goes straight to what the person thinks is most obvious – in this case, sin and the devil – and doesn't spend time working through the complexities of a person's situation. The irony of such lazy explanations is that if a person with a severe mental health challenge were to say to someone that the devil is within them, they would probably be hospitalized; yet the "outsider" seems to be able to say whatever he or she thinks, and it is considered to be acceptable.

While the Bible and theology are central, they need to be treated with care, caution, thoughtfulness, respect, and compassion. Jesus tells us that the sum of the law and the prophets is to love God, to love one another, and to love ourselves (Matthew 12:30–31); Peter tells us that "God *is* love." The danger with a negative mental health hermeneutic is that we forget about love, we overlook the experiences of the individual, and we try to force their experiences into a framework we think we already know rather than listening, hearing, understanding, and accompanying.

## *Disability and Healing*

If we now look to the issue of healing in the Bible, some useful complementary perspectives begin to emerge. It will be helpful to highlight some of the pitfalls and some ways of dealing with them through a brief exploration into Jesus's healing ministry. It is extremely important to consider a few basic points about these texts and their overall import in Christian life. First, it is important for practitioners and Christians to make a distinction between *curing* and *healing*. Although these are often conflated in contemporary reading and interpreting of the Gospels, Jesus cured relatively few people or removed their diseases. Yet, healing, especially the restoration to spiritual wholeness of not just a few but entire communities, was at the center of Jesus's ministry.

Second, many argue that whatever curing Jesus did needs to be interpreted within a constellation of signs indicating that He was the Messiah [20, 21]. In other words, it is vital that we read these stories *theologically* rather than medically. Of course, they are acts of love and compassion, but they are primarily statements about Jesus. Jesus cures and forgives sins. Who can forgive sins? Only God can forgive sins. Jesus is God. That basic pattern of revelation runs throughout the healings in the Gospels. They are much closer to a social than a medical model: healing is equal to reconciliation, inclusion, and a place within the community for those whose

differences had excluded them. Although it is understandable that misreading these curing stories may cause people with disabilities to feel objectified by Jesus, by focusing on a broader understanding of healing, we can see that Jesus's words and actions often demonstrate deep and inclusive care to people on the outskirts of community life.

A third point that needs to be underscored is that the connection people often draw between sin and disability from these stories is a misguided interpretation of Jesus's ministry. In many cases, Jesus is moved by the faith of people with disabilities and provides curing as a part of healing, especially when it is welcomed (see the story of the paralyzed man in Matthew, Mark, and Luke; Bartimaeus in Mark 10; or the blind man in John 9). But Jesus does not stipulate that faith or repentance is a prerequisite to healing, nor does He indicate that being cured is the essence of what it means to live a life of faith for people with disabilities. Although these may seem like subtle distinctions, it is important to state that the whole of the Gospel does not make an argument for the removal of disability, but rather emphasizes the Good News that Jesus forgives all of us, alike, of our sins, liberating us to live flourishing lives of faith and freedom.

Fourthly, and specifically in relation to mental health, we must be careful to avoid reading twenty-first-century diagnoses back into second-century Mediterranean culture. The history of psychiatric diagnosis is one of controversy and constant change. What we know at this moment in time is quite different from what we thought we knew 50 years ago and will probably be different from what we may know in 10 years' time. That is not to suggest that somehow mental health challenges don't exist. It is simply that our knowledge of what they are, what causes them, and what they mean is constantly shifting and changing.

It is therefore a mistake, for example, to read the story of the Gerasene demoniac as an example of schizophrenia as some have suggested**.** The diagnosis of schizophrenia had not been invented at that time, and it remains controversial today [22]. Are we then to assume that this is a story about demons? This is the answer that the story claims. However, what we cannot then do is to take the experiences of great strength, self-abuse, or elated behavior as evidence that someone with such experiences today is demon possessed. When we read the Gospel stories and their accounts of demon possession and place them alongside the descriptions of severe mental health challenges such as schizophrenia, major depressive disorder, or bipolar depressive disorder, it is clear that they are not the same things. Apart from anything else, most of the accounts of demon possession are related to physical conditions, and we rarely hear Christians attributing back pain to demons (Luke 13:10–17)! But we do hear people attributing demons to voice hearing or hypomania. This is a serious mistake that can easily be addressed by reading the Gospels. Yes, the Gospels speak of demons. No, they do not refer to what we now call mental health challenges.

Finally, ministries of healing can often conflate these sets of concepts with respect to disability (curing and healing and sin and disability) to the extreme, distorting the Good News of the Gospel and preying on the vulnerability of people with

disabilities and their families. By focusing on the "problem" of disability and God's will to remove disability if persons have "enough" faith, these ministries undermine the humanity of disabled people, their fundamental belonging to God, and the core of Christianity. However, if we read the healing stories with a focus on *healing* rather than *curing*, *inclusion* rather than fixing and mending, we get quite a different picture which offers a more accepting and holistic view of disability. The suggestion that disability and sin or evil are inevitably tied together in scripture is simply inaccurate. Although there are scriptures that demonstrate some people were ostracized from social life due to their mental and bodily conditions, it is also very clear from the scope of Old Testament theology, from the extension of Abraham's blessing unto the world, to Jesus's ministry to the Gentiles in the New Testament that the Bible ultimately condemns such discrimination and exclusion of people on the basis of cognitive or physical differences.

## *Using the Bible Faithfully*

The Christian Bible provides powerful resources that can enable Christian believers to faithfully wrestle with suffering and injustice. The Gospels bring us hope and understanding of who God is and who we are before God. The lament psalms allow us to cry out to God in the midst of our pain and suffering. The book of Job calls us to recognize the importance of contemplation and to learn how to love God simply for God's sake. The Bible is thus a potential source of help in times of sadness and joy. Importantly, scripture demonstrates that it is never unfaithful or inappropriate to ask ultimate and difficult questions of God. We are told to wrestle with God and to plead with God for release, wholeness, and healing. Inviting faith into the conversation when it comes to the meaning and variety of experiences of disability is to introduce a vital new language through which people can express thoughts and feelings that might otherwise be overlooked or repressed.

Beyond the narrow vantage point of the healing scriptures, the Bible presents a myriad of stories about persons with disabilities who God uses in tangible, compelling ways to do God's ministry in the world (see, e.g., Moses in Exodus 4; Mephibosheth in 2 Samuel; Bartimaeus in Mark 10; and the woman with the issue of blood in Matthew, Mark, and Luke, to name just a few). Recent biblical scholarship has sought to reread the biblical narratives with attention to the ministry and agency of people with disabilities and mental health challenges [15, 17, 23–26] Hence, it is vital that practitioners recognize the complexity and diversity with which Christians have interpreted disability through the various texts in the Bible. As demonstrated, the Bible can be an extremely comforting and insightful tool to understanding disability, but there are also many ways in which the Bible has been misused to oppress and marginalized people with disabilities. This is why emphasizing the agency of patients to interpret their experiences for themselves is also a faithful and thoughtful way practitioners can engage people of faith.

## The Voices of People with Disabilities

The Bible also makes clear that throughout history, despite shifting cultural and spiritual frameworks, a variety of bodily and mental conditions have been the norm for human existence. Indeed, today some 20 percent of the population lives with disability. Hence, although persons with disabilities constitute a minority of the human population, they form one of the largest minority groups on the planet. Especially in the West, the word disability has been reclaimed as a critical consciousness for persons who have been discriminated against on the basis of physical and cognitive differences and therefore still find themselves disproportionately impoverished, undereducated, and unemployed. Activists and advocates in the Disabled People's Movement around the world fight for civil rights legislation that provides the appropriate supports so that people with disabilities can live independently in an able-bodied world. These disabled activists and scholars have done important work in critiquing what appears to be normal in the world, identifying ableism as a source of injustice for people with disabilities, and affirming the dignity of people with disabilities as human beings. They champion the popular slogan "Nothing about us without us!" uplifting the importance of disability justice and the pride and agency persons with disabilities have brought to their own liberation.

Accordingly, practitioners and Christians alike should take seriously how people with disabilities themselves wrestle with the meaning, embodied, and social experiences of disability in the world. Too often persons with disabilities have been infantilized or patronized on the basis of presumed incompetence, or their own perspectives have been sidelined, and medical experts, clergy, or other leaders have presumed authority on their behalf. It goes without saying that persons with disabilities need to be communicated with directly regarding information and decision-making regarding their health concerns: when interacting with disabled persons, including those with any form of mental illness, speak directly to the person, rather than to an interpreter or caregiver that may be present. If that interpreter or caregiver is speaking over the patient, do your best to carve out space and time for the patient to interact on their own terms.

Listening not just for the patient's statements or questions but for the broader context or worldview embedded within them helps to implicitly establish the importance of the patient's point of view. Asking follow-up questions and devoting time to dialogue and discussion foregrounds the humanity of patients in their care: this is something Jesus did effortlessly in His interactions, it's something ER's neurologist did thoughtfully, but it's something too often both pastors and practitioners discount. At the outset of this chapter, we talk about making space for doubt in the life of faith, the importance of acceptance and affirmation of disabled lives, and the harm misinterpretations of scripture have inflicted in objectifying and discounting people with disabilities. By lending people with disabilities opportunities to process their feelings and experiences, affirming the complexity of these experiences, and the dignity of their lives, especially in the eyes of God, practitioners can present encouragement and remind people with disabilities and their families that they are not alone.

The activism and leadership of disabled people have helped to illustrate the flourishing, joy, and goodness in disabled lives, alongside realistic persistent challenges of injustice, pain, and suffering [27]. Simply asking a patient "What are you hoping to gain from today's visit?" helps to acknowledge how this pursuit of medical treatment fits into a patient's overall pursuit of health and well-being and puts their agency front and center in the interaction. Acknowledging a broad variety of ways to flourish in this world testifies to the life-sustaining, creative work of the Holy Spirit among us, the ultimate advocate in the Christian life [15]. Too often, in both the Church and the medical room, patients' concerns and experiences have been discounted.

## Conclusion

This chapter demonstrates that although Christianity and medicine offer insightful tools for understanding, well-being, and human flourishing for people with disabilities, too often they have been used to discriminate against people with disabilities by marginalizing disabled bodies and ways of life as aberrations or problems. By grounding human experiences as Christians in God's creating, sustaining, and redeeming work in the world, through Jesus Christ and the Holy Spirit, we present a broader vision for health, human flourishing, and even healing, anchored in the truth of God's love, Christ's incarnation, and the Spirit's advocacy. By becoming aware of problematic cultural, biblical, and theological interpretations of disability, physicians can be partners in creating space for faithful meaning making and flourishing by placing the dignity, goodness, and agency of persons with disabilities in the foreground of their medical care. We hope this chapter empowers physicians to recognize spiritual and theological interpretation and conversation as a valued part of wellness and well-being and that they play a vital role in the flourishing and vitality of people with disabilities.

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# Chapter 10
# Miracles and Care at the End of Life


**Gloria E. White-Hammond and John R. Peteet**

Several years ago, my beloved friend Margie[1] was diagnosed with breast cancer. She asked if I (GWH) would accompany her for the initial visit with the oncologist. Among Margie's many endearing qualities are her indefatigable love of God, and her unrestrained boldness to testify about the goodness of the Lord to anyone, anytime, and anyhow. As we waited in the examining room, she acknowledged her anxiety and asked if I would pray with her. She told me that there was one thing she wanted her doctors to understand: she knew, without a doubt, that God was going to heal her. As both a pastor and a physician, I felt a need to respect and honor her beliefs. With hands held and heads bowed, we prayed to affirm her trust in God as a Divine Healer.[1]

Just after our finishing "Amen," a nursing assistant knocked and entered the room. We both introduced ourselves; the nursing assistant sat at the desk and began typing. "What brings you here today?", she asked Margie. Of course, a simple answer was "breast cancer," but Margie launched full throttle into a testimony about her fervent and heartfelt beliefs: how and when Jesus had saved, sanctified, and filled her with the Holy Ghost and, from that moment, her life had never been the same. God was faithful without a doubt and God was in the healing business. God was going to heal her of breast cancer.

[1] Story used with permission.

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As Margie shared her testimony, I looked at the nursing assistant. With hands suspended over the keyboard, she looked stunned. I wondered what she might be thinking, how would she respond to Margie's sincere conviction? With unrestrained snickering to chide her? Well-researched statistics to "enlighten" her? Or would she even acknowledge Margie's sentiments?

But as Margie continued to speak about her religious faith, the nursing assistant's body language seemed to soften, and she looked curious. Margie ended her sharing with an enthusiastic, "Hallelujah, thank ya, Jesus!", and the assistant rested her hands in her lap and leaned toward Margie. With a hint of a smile, she asked, "So you're spiritual, right?" Immediately, Margie's anxiety dissipated and she grinned broadly, breathed a sigh of relief, and said, "Yes ma'am, that's right. I'm spiritual."

The nursing assistant's simple but powerful and respectful response acknowledged and validated that Margie's spiritual beliefs were core to her identity and critical to her medical care. Her faith in God to heal her was, according to Margie, the most important data for her clinicians to take away from their initial encounter. During the next 3 months, Margie underwent a lumpectomy and radiation therapy. I was privileged to accompany her to several appointments. Everywhere she went, she let others know how important her faith was to getting better, and she often felt encouraged by the warmth from her providers and their respect for her religious beliefs.

At the conclusion of her treatment regimen, we celebrated her clinicians' declaration that she was "cancer-free" as evidence of God's faithfulness. Two years later, however, the cancer recurred with metastases. After an initial course of chemotherapy provided marginal improvement with significant side effects, Margie declined additional treatment. She said that she "knew where she was going" and she wasn't afraid of dying. Three years after the initial diagnosis, she died at home with hospice support and with her loving family as her caregivers. Near the end, her family and I joined hands, prayed, and sang.

Spiritual care that recognizes a patient's religion and/or spirituality and attends to their spiritual needs has been incorporated into national care quality guidelines, including those of the 2004 National Consensus Project for Quality Palliative Care [1] and the Joint Commission [2]. Data suggest that provision of spiritual care by medical teams to terminally ill patients—in Margie's case, "so you're spiritual, right?"—is associated with better patient quality of life (QoL), greater hospice utilization, and less aggressive medical intervention at the end of life (EoL) [3]. Research has also shown that associations with more aggressive care are stronger in high religious coping and racial/ethnic minorities [4]—raising the question of whether this is related to their waiting for a miracle. Interestingly, this association is somewhat mitigated by provision of spiritual care by the medical team [3]. Despite these findings, and the desire of most patients to have their spirituality incorporated into their treatment [5], oncology providers often underestimate the importance of spirituality to patients, and provide relatively limited spiritual care [6].

As with Margie, religion is important to many African-Americans. According to the 2014 U.S. Religious Landscape Survey [7] conducted by the Pew Research Center's Forum on Religion and Public Life, African-Americans are significantly

more religious than the broader US population on a variety of measures. With regard to belief in God, 94% of Black Americans are absolutely certain or fairly certain that "God is real," compared to 81% of Whites. Seventy-five percent of Blacks report that religion is very important in their lives, and 79% Blacks identify as Christian (compared to 71% of Americans overall). According to the Pew study, compared to other racial and ethnic groups, African-Americans are the most likely to report a formal religious affiliation, with 87% describing themselves as belonging to a specific religious group. African-Americans also report greater attendance at religious services than other racial groups (47% at least once a week; 36% once or twice a month or a few times a year), and greater participation in prayer, scripture study, and religious education groups (39% at least once a week; 14% once or twice a month).

Belief in miracles is prevalent among African-Americans. According to Pew's 2007 U.S. Religious Landscape Survey [8], belief in miracles is fairly common—79% of all Americans—but 84% of African-Americans said they believed in miracles. The strength of the belief and adherence to the belief that "God is in the miracle-working business" is in my experience qualitatively different among many African-Americans. For them, belief in miracles is not simply an abstract theological construct that can be rationalized or reasoned away. The God of first and last resorts was a God of miracles. Survival of the treacherous Middle Passage on ships that transported enslaved Africans to the Americas was evidence of the miraculous. When they could not practice their traditional religions, the enslaved Africans resonated to the God of Christianity. The Biblical miracle narratives were particularly compelling—from the accounts of God's miraculous deliverance of Hebrew slaves who managed to thrive despite the brutality of their Egyptian masters to the many stories of Jesus's miraculous works. African-American Christians often frame as miraculous that they not only survived but thrived despite the brutality of slavery, the inhumanity of Jim Crow, and the ongoing injustice of racism.

Belief in God's healing power is also informed by Biblical scripture which, according to the Pew survey, is considered by 53% of African-Americans to be the word of God. Scriptures such as Psalm 41:3, "The Lord sustains them on their sickbed and restores them from their bed of illness," and Psalm 103:3, "Praise the Lord, my soul, and forget not all his benefits—who forgives all your sins and heals all your diseases…," are often identified as "healing scriptures" and cited during prayers for seriously ill patients.

Traditionally, testimony services are a weekly staple in Black churches. Participants "testify" by sharing stories about their experiences of God's faithfulness. Often everyday events are framed within the context of the miraculous, i.e., "He woke me up this morning and started me on my way." Events that others might attribute to luck, or happenstance or being in the right place at the right time, are attributed to the deliberate hand of God. Participants often share "prayer requests and praise reports" regarding serious illnesses. They may pray as a group for healing for an ill member such as Margie. A common theme in these accounts contrasts their mistrust of clinicians vs. their confidence in God. "My doctor said this, but Dr. Jesus said that." The pervasive feelings of distrust reflect both past injustices and present-day realities.

How can clinicians engage in more open and effective communication with patients and families who believe in miracles? The first step is a spiritual assessment, conducted from a stance of curiosity and wonder. "I wonder if you'll tell me about yourself." "I wonder about your family." "I wonder about where you live." "I wonder about what matters to you because I want to see you." "What is a miracle to you?" "Have you ever experienced a miracle?" "What has been your experience with the miracle?" This kind of curiosity can open patients up because, rather than being seen, so many have been overlooked and dismissed. To wonder and to ask is to say, "I see you and you matter." Even if we are unable to make policy changes that will redress prevailing injustices, we can wonder about the racist in me, about the sexist in me, about what it means to you to be sick, about how do you navigate all this, and what are your sources of hope.

In addition to being curious, it is helpful to remember that there is a process by which someone moves from being convinced of their healing to accepting that it may not happen—a process which is facilitated by information, communication, emotional support, guidance, and direction (Fig. 10.1). Someone may start by saying "I know God will heal me" and later say "I know that things are progressing but I am claiming even now (once I can work through my own confusion and fear about this) that God has healed me," moving to as the illness progresses, "I trust that God is healing me"; to as things continue to become more complicated, "I hope that God has healed me"; and to "not my will but thine be done." I as a pastor often see people get there but in their own time. Most have learned to stay in conversation and relationship with, rather than try to lead them through the process.

When congregants come to me and say they are ill, I pray this prayer with them at the beginning and throughout (Table 10.1):

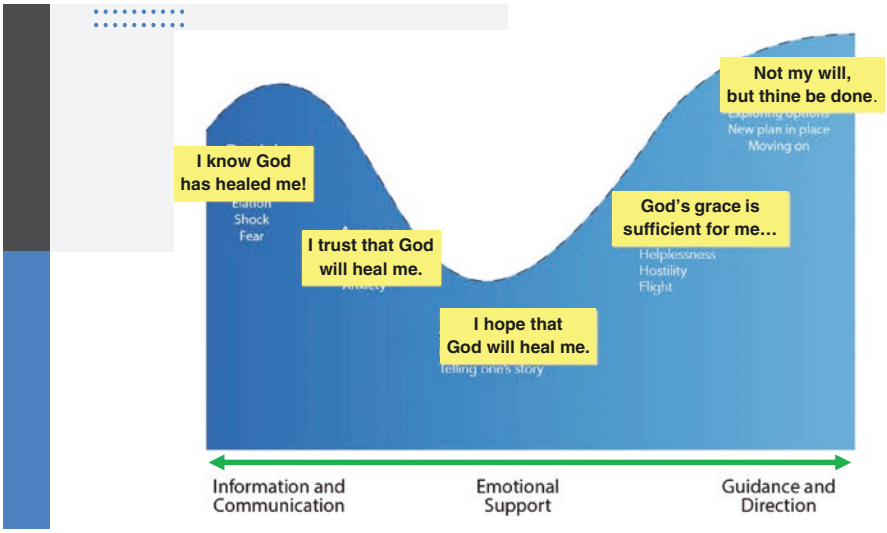


**Fig. 10.1** The process of coming to terms

**Table 10.1** Pastor Gloria's prayer and Dr. Gloria's conversation

| Pastor Gloria's prayer | Dr. Gloria's conversation |
|---|---|
| Gratitude for God's faithfulness | Express gratitude for the patient |
| Acknowledge emotions | Acknowledge emotions |
| Affirm trust in God | Affirm the patient's faith |
| Ask for healing | Affirm the hope for healing, and I worry… |
| Ask for strength to endure | Commit to support ALL the way |
| Pray for the wisdom of clinicians | Appreciate thoughts and prayers for clinicians |
| Express, however, the ultimate confidence in God | Affirm the patient's faith |
| Gratitude for God's faithfulness | Express gratitude for the patient |

Gloria White-Hammond, MD, MDiv., 2019

> (Beginning with gratitude) God thank you for your grace and for your Amazing Grace in our lives. We've seen it, we've experienced it and now that ___ has this diagnosis and quite honestly, is upset (name those emotions – e.g. afraid, scared, incredulous). We know that you God can handle those emotions. Based on our experience we affirm our trust in you. Remembering that the scripture says that you promise to "heal all our diseases", God we are asking you for healing. We are asking that you move throughout ___'s body and that there would be a healing. We ask you throughout the course of this for the strength to endure - for ___ to endure, for ___'s family members to endure, and for our church members to endure. Help us to get through this. We pray for the wisdom of the clinicians. Thank you for their knowledge. We pray that you would give them your Divine Wisdom as they make decisions about ___'s care but ultimately our confidence is in you God (gratitude for God's grace).

For a patient who is not my congregant, I might also express gratitude for the patient:

> "Thank you for coming here." "Thank you for allowing us to care for you." "Thank you for allowing us to be in a relationship with you and your family." "I understand that you're afraid and I hear your frustration. I hear that and as you've talked to me (because I've done my spiritual assessment) it's clear that your faith matters to you. I want to encourage you to apply that faith as we move through this experience and to affirm your hope for healing. I worry because we are also grounded in our experience but I'm committed to supporting you all the way. I know (from our spiritual assessment) that prayer is important to you, so if you feel that you want to pray for us we are grateful for whatever feels comfortable to you."

My goal here is to honor their spirituality and show that I am committed to staying with them all the way.

Unlike palliative medicine, psychiatry has not adopted spiritual care as one of its aims, and clearly not all psychiatrists will feel able or inclined to join Christian patients in such forms of prayer [9]. However, as members of the medical team frequently consulted to help assess anxious and/or mistrustful patients, or those who like Margie can seem "hyper-religious," they can recognize when they need spiritual care, and help them to find it in a pastor, chaplain, or another clinician of faith. Recognizing the nuances of patients' beliefs in miracles can also help the medical team to avoid missteps, for example, by assuming that the patient would refuse an offer of hospice [10]. Through collaborating with hospital chaplains [11],

psychiatrists can become better attuned to the spiritual dimension of their patient's lives, and more able to help their Christian patients draw upon the unique resources they have for living and dying well [12].

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# Chapter 11
# Addiction and Twelve-Step Spirituality

**David B. Hathaway and Michael Dawes**

## The Intersection of Christianity and Twelve-Step Spirituality

> God give me the serenity to accept things which cannot be changed;
> Give me courage to change things which must be changed;
> And the wisdom to distinguish one from the other. [1]

Alcohol and other substance use disorders are among leading causes of preventable death worldwide [2]. On a given day in the United States of America, an estimated 128 persons will die from opioid overdose, 241 will die from alcohol-related disease, and 1,315 will die from cigarette smoking-related illnesses [3]. Societal costs of substance use are estimated to exceed $740 billion each year [4]. These statistics do not convey the untold pain and suffering endured by persons with substance use disorders, their families, friends, and neighbors.

Given the societal impact of alcohol and other substance use disorders, effective treatments are desperately needed. A recent meta-analysis found that participation in Alcoholics Anonymous (AA) is as effective as – if not more effective than – other treatments of alcohol use disorders [5]. And active engagement strategies used by clinicians to facilitate active AA and other twelve-step (TS) engagement (i.e., twelve-step facilitation, TSF) are believed to increase the likelihood of persons with

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alcohol use disorders and other individuals struggling with other addictions to actively participate in twelve-step groups [6].

Of note, while terms like "alcoholic" and "substance abuser" remain common parlance in AA/TSF, recent research suggests that use of these terms may promote attitudes of dismissiveness and condemnation (i.e., stigma) toward persons who struggle with problematic alcohol/substance use and reduce access to treatment resources. Therefore, throughout this chapter, we will favor the use of more modern terminology (e.g., "persons with an alcohol use disorder" and "persons with a substance use disorder") [7].

Three key principles undergird the healing process that occurs with twelve-step self-help recovery groups and TSF: (1) acceptance, (2) surrender, and (3) active involvement in twelve-step meetings and related activities [6].

The authors of this chapter are clinicians who treat patients who struggle with various addictions and co-occurring mental health disorders. We write this chapter to explain why TS participation may be an important component of treatment for many, but not all, persons who are seeking spiritual renewal and recovery. We will briefly review the intersection of TS spirituality and Christianity, to examine the historical background and Christian origins of AA/TS/TSF; review putative mechanisms that promote recovery from addictions; compare and contrast some TS self-help recovery groups and TSF; provide case examples; examine the expansion of peer-led mutual help groups, including secular support groups; and close with future directions.

## Christian Origins of Alcoholics Anonymous

AA/TS/TSF is rooted in both secular and religious traditions. The Hebrew Bible, which comprises the bulk of Christian sacred scriptures, is replete with warnings against various forms of vice and excess, including heavy alcohol use, though exceptions were made for moderate and/or occasional drinking (e.g., "Alcohol is for the dying, and wine for those in bitter distress" [Proverbs 31:6]). In Scripture alcohol is first introduced in the story of Noah, who personifies the paradox of alcohol as a means of escape (e.g., from unbearable realities) but also as a source of trauma for its user and those closest to him when consumed in excess.

Alcohol is also explicitly addressed in the Christian New Testament: Christ's first miracle was turning water into wine; the sacred ritual of communion – instituted for the church at the Last Supper prior to Christ's crucifixion – entails regular, intermittent consumption of small portions of wine; early Christians filled with the Holy Spirit at the Jewish feast of Pentecost were ridiculed for supposed intoxication [8]. The Apostle Paul minces no words in his epistle to the ancient Greek seaport city of Corinth: "[None] who are addicted to hard drinking… will inherit God's Kingdom" [1 Cor 6:10 Weymouth New Testament]. As Christianity spread throughout the globe to become a dominant worldview in the centuries following, such views on alcohol became increasingly commonplace [9].

For Western society in the modern era, the novel distillation techniques and industrialization facilitated the widespread consumption of high-proof alcohol. As profound societal consequences ensued, some called for moderation in drinking,

while others advocated complete abstinence. From 1920 to 1933, the sale of alcohol was legally prohibited in the United States. Despite such far-reaching legal measures, alcoholism use remained widespread.

Modern medicine was not exempt from the effects of alcohol and substance use. The introduction of the hypodermic needle and the mass production of cigarettes increased the addictive potential of opioid and tobacco, respectively. The Austrian neurologist Sigmund Freud (1856–1939), who founded the discipline of psychoanalysis, proposed – based on personal experience – that opioid addiction could be relieved by cocaine, only to find himself trading one addiction for another [10, 11]. The Swiss psychiatrist Carl Jung (1975–1961), seemingly acknowledging the relentless grip that alcoholism had on individuals, told a wealthy American patient that his case was hopeless absent religious conversion [12].

On Mother's Day, 1935, Henrietta Seiberling, a wealthy college-educated woman from Akron, OH (USA), encouraged two men whom she was hosting in her home to have hope that Christian faith could help promote their recovery from severe alcohol addiction. Seiberling was a leader in the local branch of the Oxford Group, an evangelical movement founded by Frank Buchman, a convert of revival services held in Keswick, England. After his conversion, Buchman sought to return to "first-century Christianity," de-emphasizing hierarchy, doctrine, grand edifices, and other trappings of formalized religion. Seiberling devoted herself to praying for her guests' recovery. She met with them regularly to discuss the importance of private prayer, anonymity, avoidance of external funding sources, and total reliance on God. Over several months, other alcoholics were invited to attend these meetings of the "alcoholic squad of the Oxford Group," which later became known as Alcoholics Anonymous [13].[1]

For one of Seiberling's early guests, William G. Wilson ("Bill W."), this experience was not his first encounter with evangelical Christianity. Though previously averse to religion, Wilson had a year earlier heeded a friend's advice to begin attending local meetings of the Oxford Group in New York City led by Episcopalian pastor Sam Shoemaker, who emphasized the importance of introspection, admission of flaws in one's character, and seeking to make amends for past harms done to others. Soon after attending his first Oxford Group meeting, Wilson resumed heavy drinking and fell severely ill. Though still averse to religion, Wilson cried out from his hospital bed, "If there is a God, let Him show Himself!" Wilson then recalled experiencing a sensation of ecstasy followed by profound tranquility: "Now for a time I was in another world, a new world of consciousness… a wonderful feeling of Presence." Wilson would wrestle with intense cravings following this experience – which ultimately led his reaching out through Oxford Group contacts to Seiberling for support – but he never drank again.

Seiberling's other guest, a surgeon named Robert H. Smith ("Dr. Bob"), also met Seiberling after he began attending the Oxford Group. Dr. Smith was introduced to the Oxford Group by his wife, Anne Smith, who had earlier attended a lecture given by Buchman. Dr. Smith nonetheless continued to drink for 2 years until Seiberling introduced him to Wilson in 1935. In contrast to Wilson's tendencies toward externalizing behaviors and social drinking, Smith was introverted and drank alone. Despite their differing temperaments, Wilson teamed up with Smith to try different methods to promote recovery from alcohol use disorder (or, "alcoholism," as it was then called).

[1] Source used throughout this section.

Smith's professional experience as a physician – combined with Wilson's personal encounters as a patient – doubtless contributed to the development of AA's traditions. Several years prior to his hospital bed epiphany, Wilson had been treated by a New York City medical doctor (Dr. William D. Silkworth) who regarded "alcoholism" as a disease (i.e., a physical allergy), a view which contrasted sharply with the then-prevailing societal view of the condition as a form of moral failure. At the time, hospitals barred admission of "drunks"; yet with the assistance of a Catholic nun (Bridget D. M. Gavin, or "Sister Mary Ignatia") assigned by her church to serve as the admissions gatekeeper at Akron hospital, Smith began admitting persons to the hospital for "gastritis" as a cover to provide medical treatment.

AA's organizational tenets became accessible to a wider audience after Wilson published a book entitled *Alcoholics Anonymous* in 1939. *The Big Book*, as it soon came to be called, featured "12 steps" drawn from various Christian traditions, especially those of the Oxford Group [14, 15]:

1. We admitted we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Thus, with minimal reference to modern medicine, psychology, or psychiatry (though Wilson did later credit Jung and Silkworth for their contributions to AA), the 12 steps were laden with unmistakably religiously themes. They explicitly referenced traditional elements of Christianity, "God," "prayer"/"praying," "meditation," "His will," and "spiritual awakening," but made more guarded reference to others: sins ("wrongs," "shortcomings," "defects of character"), confession ("admitted to God…"), self-examination ("take personal inventory"), submission ("turn our will… over to the care of God"), restitution ("making amends"), and evangelism ("carry this message to alcoholics"). Still, some of the 12 steps were ambiguous and open to personal interpretation. The phrase "God as we understood Him," while also originating in the Oxford movement to refer to persons in various stages of spiritual maturation, created ambiguity as to which deity (if any) this "higher power" referred.

Wilson recognized and even embraced this ambiguity. He saw an expanded interpretation of the deity (e.g., viewing "the AA group" as the higher power) as a means to broaden AA's appeal and reach to more individuals with alcoholism. Personally, he dabbled with non-Christian religious experiences (spiritualism) and even the use of nonalcoholic substances (LSD). For Wilson and other AA participants, God seemed to be more the means to the end (sobriety) than an end in and of itself. This inclusive view of deity did indeed enhance AA's reception among nonreligious persons, but was met with mixed reviews by the Christian community at large [13, 16].

Nonetheless, in the decades since its founding, AA expanded to include over 2 million members worldwide, many of whom credit AA and the 12 steps for their sustained recovery from alcoholism. Offshoots of AA and the 12 steps now include organizations supporting partners of persons with alcoholics (Al-Anon), adult children of alcoholics, as well as persons struggling with drug use (e.g., Narcotics Anonymous, or NA), gambling, sexual compulsions, and other problematic behaviors.

**Case 1: Finding Recovery Through the 12 Steps**

Eric got his first buzz at the age of seven at a family gathering when a mischievous cousin laced his drink with alcohol as a prank. Abandoned by his father not long thereafter, his mother tried her best to raise Eric in the Christian faith, taking him to weekly church services and having him commit scripture to memory. Eric excelled academically and was known for his caring, endearing demeanor. But throughout his youth, Eric found himself hounded by the pain of his father's absence and urges to relive his childhood high. In his late teens, he succumbed to these cravings, experimenting with cocaine and other drugs. For the next few years, Eric found himself increasingly dependent to drugs and especially alcohol, cycling through a series of rehab treatment programs, each of which he found ineffective, in large part due to the ready availability of substances within the "treatment" programs.

By his mid-twenties, Eric was married, father to a young child, and struggling to hold onto a job due to his heavy alcohol use. Heeding the counsel of pastor and family, Eric started in an over yearlong faith-based residential program called Teen Challenge. Eric found that this program's strict visitor policy separated him from his wife and child; however, so after just a few weeks with Teen Challenge, he switched to another residential program across town sponsored by the Salvation Army. The Salvation Army program had a more relaxed visitor policy, hosting in-house church services each Sunday followed by a dinner prepared by staff for residents and visiting family members. During the week, residents would attend local twelve-step program meetings. Eric established a relationship with a sponsor and started "working the steps" while in the Salvation Army residential program. Upon completing the program, he moved back to live with family but continued his involvement with the 12 steps, attending local Alcoholics Anonymous meetings on a daily (and on particularly challenging days even twice daily) basis, which allowed him to achieve several years of continuous sobriety by his late 30s. *Continued below*

## Outcomes and Mechanisms Common to Twelve-Step Recovery Groups

A growing body of literature has examined the mechanisms and effectiveness of AA/TS/TSF. A 2020 Cochrane meta-analysis of 27 studies, with 10,565 participants, found robust evidence that AA is as effective – and possibly more effective – in promoting long-term abstinence from alcohol in comparison with other standardized treatments such as cognitive behavioral therapy and motivational interviewing [5]. At the same time, the Cochrane study showed that AA attendance was associated with significant healthcare cost savings compared to other treatments. Furthermore, evidence for TSF in treating alcohol use disorder is robust and well established [6], and preliminary findings are promising for the effectiveness for TS and TSF for other types of addiction, including stimulants and opiates [6].

## Why and How Do AA, TS, and TSF Work?

Three key principles are often thought to be central to the effectiveness of TS and TSF:

1. *Acceptance* that drug addiction is a chronic and often recurrent disease that often becomes unmanageable, and that willpower alone is insufficient to achieve abstinence and recovery
2. *Surrender* that requires the individual giving up control to a higher power or authority and accepting fellowship and support from others in recovery
3. Active and sustained *involvement* in twelve-step group meetings, and related activities including working with a sponsor [6]

But what are the mechanisms by which these produce positive outcomes? And to what extent does spirituality – and particularly Christianity – play a role?

TS/TSF clinical research has focused on three active ingredients: spirituality, cognitive shifts, and psychological variables [17].[2]

**Spirituality** Spirituality has been variously defined, but generally refers to one's relationship to something larger than the self which gives life meaning[2]. Peteet has suggested that twelve-step programs address the spiritual needs of addicted individuals in the domains of identity, integrity, an inner life, and interdependence [18]. For example, each speaker at a meeting acknowledges his identity by stating: "Hello, my name is ___, and I am an alcoholic (addict)." AA members emphasize that the program is "spiritual, not religious," and point out that persons who do not identify as spiritual or religious (e.g., self-professing atheists) can benefit from AA just as much as those who identify as spiritual or religious. However, atheists are

[2] Reference used throughout this section.

more likely to be comfortable with a secular, science-based approach, and less likely to accept referrals to AA and attend meetings than persons who are open to religion. (See the section below, "Finding the Right Mutual Help Group for Your Patient" for additional information on secular groups.) (Fig. 11.1).

Regardless of initial beliefs or worldviews, however, research has shown that patients who attend AA meetings regularly experience an increase in their level of religious belief (religiosity), which parallels decreases in alcohol consumption [19].

**What Does Involvement in AA Consist Of?** Surveys of AA members have identified active ingredients of behavior change including the following [17, 20]:

- "Working the steps"
- Reading AA core literature
- Telling one's story at an AA meeting
- Having a sponsor/sponsorship

Given the religious connotations of the first two, it is not surprising that many continue to regard spirituality as an essential ingredient in AA's recipe for personal growth and change.

Partly in reaction to the spiritual emphasis of AA, there has been in recent decades a proliferation of explicitly non-spiritually oriented recovery groups, such as SMART Recovery. Comparative effectiveness research examining differences among these approaches is complicated by several confounds: many individuals who attend nonreligious recovery groups also attend AA, and recovery groups are by their very nature anonymous. Further research is needed to compare these contrasting approaches while controlling for such potential confounders.

**Cognitive Shifts** The 12th step refers to a "spiritual awakening." AA literature notes that "with few exceptions, our members find that they have tapped an unsuspected inner resource, which they presently identify with their own conception of a Power greater than themselves" (pp. 569–570). Twelve step-oriented therapists seek to promote cognitive shifts throughout the course of treatment, such as considering oneself powerless over alcohol. Other examples of cognitive shifts promoted in AA include cognitive deflation (e.g., recognition of one's own faults and powerlessness over alcohol), and increased sense of self-efficacy (e.g., through reliance on "God"), and even improved cognitive functioning with long-term abstinence.

Still, other therapies (e.g., CBT) seek to promote cognitive shifts and reframing. Why would AA/TSF be superior to CBT in Project MATCH and other research if the main mechanism for change was the promotion of cognitive shifts? Could it be that the cognitive shifts put in motion by AA are different than those affected by CBT?

**Psychological Factors** Changes in impulsivity, attachment, empathy, and depression have all been proposed as psychological variables mediating the changes in drinking patterns which AA affects. Kelly hypothesized that depression and alcohol use have a bidirectional relationship and that AA attendance serves as a form of behavioral activation, breaking the loop of alcohol contributing to depression and its contribution to alcohol use [21] (Fig. 11.2).

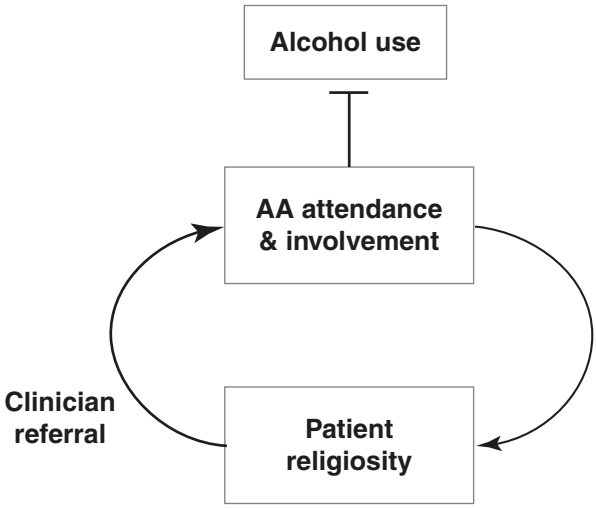


**Fig. 11.1** Persons who are less religious are less likely to attend AA meetings. On the other hand, clinicians are more likely to refer patients who are religious to AA. Still, patients who attend AA experience an increase in religiosity, regardless of their baseline level of religiosity [19]

At the same time, one might wonder if there is more to the story in terms of mediating variables, particularly considering that continuing AA attendance is associated with increased religiosity.

## Christian-Based Twelve-Step Recovery Groups: How Are They Different from Other TS/TSF?

Undoubtedly, there are twelve-step recovery groups without a Christian worldview where Christians achieve abstinence and recovery, likely due to the fundamental processes and mechanisms described in the previous section. Does Christianity add to the mix of factors that lead to recovery, and if so, how? One particular Christian-based recovery group, Celebrate Recovery, has begun to address these questions.

**What Is Celebrate Recovery (CR)?** Celebrate Recovery is an explicitly Christian-based recovery support organization, in which CR groups function under the auspices of specific churches. The CR website states that over five million individuals have participated in a CR step study and over 35,000 churches sponsor CR recovery groups. CR was co-founded in 1991 by John Baker and Rick Warren, leaders and members of Saddleback Church, Lake Forest, California. The onus for creating CR grew out of John's discomfort in expressing Christian beliefs within Alcoholics Anonymous meetings that he attended. Baker's goal, with encouragement from leadership at Saddleback Church, was to create a new type of mutual-support group where he and like-minded attendees could celebrate their recovery from addiction and problematic behaviors, by benefitting not only from the healing process that

occur with twelve-step membership but also from the healing and growth that can occur when recovery efforts and behavior are reinforced by worship experiences and candid discussion with fellow believers who share similar Christian values and worldview.

**How Is CR Different from Other Twelve-Step Recovery Groups?** CR principles include twelve-step principles common to all AA/TS groups, described previously. These 12 steps are augmented by eight recovery principles based on the beatitudes found in the Gospel of Matthew 5:1–12. According to the CR website [22], these recovery principles provide a "road to recovery" that is based on Christian beliefs and practice. The "RECOVERY" acronym specifies eight recovery principles that are foundational and transformative for Christians who aim to change their problematic behaviors by experiencing the healing elements that occur with twelve-step group process in general while also learning God's will on how the attendee should live and experience the "power to follow His will" (see "Reserve" below for details).

- "*R*ealize I'm not God; I admit that I am powerless to control my tendency to do the wrong thing and that my life is unmanageable" (Step 1):
  Happy are those who know that they are spiritually poor (Matthew 5:3a Today's English Version, TEV)

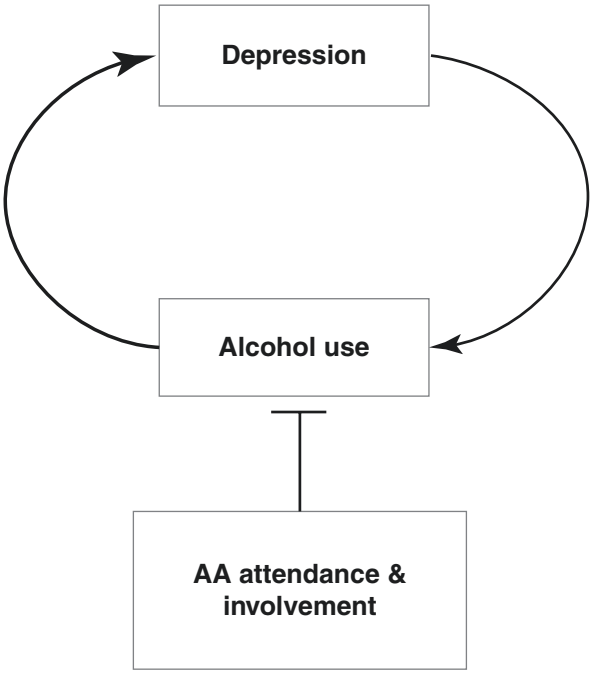


**Fig. 11.2** Kelly proposed that AA attendance and involvement reduces alcohol use, which in turn leads to reduced depressive symptoms. Decreased depressive symptoms would then further reduce alcohol use [21]

- "*E*arnestly believe that God exists, that I matter to Him and that he has the power to help me recover" (Step 2):
  Happy are those who mourn, for they shall be comforted. (Matthew 5:4 TEV)
- "*C*onsciously choose to commit all my life and will to Christ's care and control" (Step 3):
  Happy are the meek. (Matthew 5:5a TEV)
- "*O*penly examine and confess my fault to myself, to God, and to someone I trust" (Steps 4 and 5):
  Happy are the pure in heart. (Matthew 5:8a TEV)
- "*V*oluntarily submit to any and all changes God wants to make in my life and humbly ask Him to remove my character defects" (Steps 6 and 7):
  Happy are those whose greatest desire is to do what God Requires. (Matthew 5:6a TEV)
- "*E*valuate all my relationships. Offer forgiveness to those who have hurt me and make amends for harm I've done to others when possible, except when to do so would harm them or others" (Steps 8 and 9):
  Happy are the merciful. (Matthew 5:7a TEV)
  Happy are the peacemakers. (Matthew 5:9 TEV)
- *R*eserve a daily time with God for *self-examination*, *Bible reading*, and *prayer* in order to know God and His will for my life and develop the power to follow His will (Steps 10 and 11).
- *Y*ield myself to God so that I may be used to bring this Good News to others, both by example and my works (Step 12):
  Happy are those who are persecuted because they do what God requires. (Matthew 5:10 TEV)

CR meetings are run similarly to other twelve-step recovery groups, although meeting content is guided and monitored by the national CR organization. Attendees use language that generally begins with: "I am Christian who is struggling with… [problematic behavior(s)]." Mentoring and sponsorship occur at two levels, an individual level and subgroup level, with "accountability partners," who are at least 3–4 CR members who are in recovery and share similar challenges as the attendee.

**How Is CR Doing During the COVID-19 Pandemic?** During COVID-19, where face-to-face meetings are not always possible, virtual meetings have been created. Virtual meetings have changed the format, and include the following "Open share meeting format" guidelines [23]:

1. Keep your sharing focused on your own thoughts, feelings, and actions (3–5 min).
2. No cross talk.
3. We are here to support one another. We will not attempt to "fix" one another.
4. Anonymity and confidentiality are basic requirements.
5. Offensive language has no place in Christ-centered recovery group, including no graphic descriptions.
6. All members must use headphone.
7. All members must be on camera.
8. All meetings will not be recorded.

**CR and Relationship to Mental Health Practitioners and the Referral Process** Unlike some twelve-step groups that do not encourage psychiatric care and psychotropic medications when needed [MA CR representative], CR as a national organization encourages mental healthcare in addition to engagement with CR and a sponsoring church. CR leaders are encouraged to facilitate and encourage treatment for attendees demonstrating a need for mental healthcare, and for attendees requesting referrals for addiction treatment. For example, an attendee who demonstrated problematic behavior during CR meetings would be approached by CR leaders, some of whom are mental health professionals, to assess "where they are at." This CR attendee with problematic behaviors would likely be encouraged to continue with the current providers.

**Case 2: Celebrate Recovery Promoting Spiritual Identity and Healing**
While as noted above many individuals with a secular worldview are reluctant to engage with twelve-step groups because its spiritual approach has religious (particularly Christian) connotations, some Christian individuals may find AA not religious enough.

A 50-year-old disabled nurse has been treated for over 20 years by a Christian psychiatrist for dysthymia, recurrent major depression requiring multiple hospitalizations, and alcohol use disorder, currently in full remission. She has been taking medications including disulfiram and fluoxetine for more than 20 years, and has attended various Alcoholics Anonymous groups in the past. After leaving an abusive marriage in her 20s, she became a Christian, and stopped drinking alcohol for several years. During a recurrent depressive episode 20 years ago, she relapsed to alcohol use. She then became very involved with AA, going to daily meetings, obtaining a sponsor, and working all of the 12 steps. As a result, her recovery community and social supports grew. However, she continued to struggle with depression. As she became more involved in her Christian faith and local missionary activity, she became uncomfortable with the diversity of spirituality she encountered in her twelve-step group, and felt a need for more Christian support. Since finding Celebrate Recovery about 15 years ago, she has preferred CR to AA as a place where she honestly faces her problems, and experiences Christian hope that serves as a more complete framework for healing and recovery.

## Finding the Right Mutual Help Group for Your Patient

As noted earlier in this chapter, peer-led mutual help groups that treat addictions and related problems have a long history, dating back to the 1930s with the birth of Alcoholics Anonymous (AA). AA has continued to grow and now has over 2 million members worldwide. Other twelve-step groups have also prospered and grown. The twelve-step movement is likely facilitated by the culture and context in the United States, where up to 85% of the population believe in a deity or God, and

where a decentralized structure of peers, individual and group autonomy, and code of anonymity foster trust and acceptance that are foundations for recovery [5].

However, as we have noted throughout this chapter, there is no one path to recovery, not all individuals believe in a deity or God, and some recovering individuals may want a more centralized organizational structure. Not surprisingly, more secular "science-based" recovery groups exist, such as SMART (Self-Management and Recovery Training) Recovery as noted earlier. Formed in the 1990s, SMART is grounded on evidence-based cognitive behavioral therapy, motivational interviewing, and rational emotive behavior therapy developed by Albert Ellis. Key differences between SMART recovery and twelve-step recovery include the former's emphasis on changing an individual's habits and behaviors by changing an individual's locus of control, shifted internally to empower individuals to increase their self-reliance to curtail and eventually cease addictive behaviors. SMART Recovery posits that addiction is a habit rather than a disease and therefore requires methods that differ from those espoused by twelve-step recovery groups. SMART Recovery provides a four-point program that includes methods to achieve recovery: (1) building and maintaining motivation; (2) coping with urges; (3) managing thoughts, feelings, and behaviors (through problem solving); and (4) living a balanced life [23].

**Case 1 (continued): Life After Death**

By faith… Samson… turned disadvantage to advantage (Hebrews 11:32–38, The Message).

By his late 30s, Eric had achieved several years of continuous sobriety through his involvement in AA. But this all changed one wintry day when Eric found himself in a hospital emergency department after injuring his back falling down an icy stairway. Eric didn't disclose his substance use history to the emergency physician, who treated his pain with opioids and sent him home with a prescription. Eric followed up with a pain clinic, but soon found himself hopelessly dependent on the opioids. After he could no longer afford oxycodone, he turned to using heroin for the first time in his life. By his mid-forties, he had overdosed multiple times, including several near-fatal incidents. He sought out medications including buprenorphine and methadone to treat his opioid use disorder. Upon receiving take-home doses of these medications, however, he'd begin storing them up and then taking them all at once to get high.

Desperate for change, he once again checked himself into a residential treatment program. The program, offered free of charge by an urban rescue mission, featured a yearlong "biblically based" curriculum. Local community pastors would rotate through the mission, sharing their messages. Eric found himself inspired to walk the streets each afternoon sharing Christ with anyone who would listen. After completing the residential program, he enrolled in Bible college and began training to assume the pastorate of a local church where he had been ministering.

The night before Eric was to return for his final semester of Bible college, Eric's mother received a phone call stating that her son had died of an opioid overdose which seemed likely to have been intentional. Devastated by this news, she recalled that Eric, who throughout his life had suffered from severe mood swings and had survived several serious suicide attempts (also of note, Eric had previously required antiepileptics to treat recurrent seizures in his teens, and had a family history of epilepsy and bipolar disorder) had recently been feeling especially despondent after learning that his wife had decided to separate from him and that he would not be able to see his youngest son for at least a year.

Eric's mother struggled to understand how God could allow her son who had come so far and yet end his life so tragically. Eric's funeral a few days later garnered a large attendance, eliciting powerful testimonies of multiple individuals whom Eric had made contact with in recent years – many of them who had long been outcasts of society, destitute, homeless, sexually exploited, or addicted to drugs – but to whom Eric had reached through his ministry of walking the streets and sharing the Good News of faith and deliverance through Christ. Despite her doubts, Eric's mother was encouraged to see just how many persons professed that Eric had "led them to the Lord," ushering in for them a new life of hope, recovery, and freedom.

**Clinical Recommendations** The authors of this chapter suggest that rather than promoting specific twelve-step groups vs. secular groups such as SMART Recovery, it is often more prudent for clinicians to first listen to the challenges their patients have been facing and seek to understand what their patients' goals are for treatment. After carefully listening, clinicians should describe a few of the key differences that we have outlined above and encourage them to try a variety of groups, including secular groups if the patient is so inclined. With respect to non-medication treatments, patients will ultimately decide for themselves which groups feel right for them. The goal here should be for our patients to feel accepted and in a safe space, both in their relationship with us as their treating clinicians and in the recovery group they join, so as to be encouraged and supported in their ongoing recovery.

As the final case illustrates, AA/TSF may be helpful but insufficient for patients with certain severe substance use and mental health disorders. In particular, patients with histories concerning for a non-unipolar depressive disorders (e.g., bipolar disorder, which has the highest suicide rate of any the major psychiatric diagnoses) should be referred to a licensed psychiatrist or another prescriber with expertise in treating these conditions [24]. Similarly, patients for whom there are concerns for an opioid use disorder (especially if there is a history of overdose or recent/recurrent use) should be referred to an addiction psychiatrist or other prescriber with expertise

in treating substance use disorders for consideration of prescribed medications to treat opioid use disorder (MOUD: methadone, buprenorphine, or naltrexone) as well as dispensing of a naloxone overdose reversal kit [25], which may be lifesaving.

## Conclusion and Future Directions

While one size and one type of recovery group does not fit all individuals seeking recovery, it is likely that some and possibly many different recovery groups will help our patients find a community of others who will provide hope and encouragement, thereby increasing their chances of maintaining recovery and flourishing. And for Christians seeking recovery, the best fit and path may be a group such as Celebrate Recovery, which promotes recovery and flourishing with a Christian worldview. Persons with severe substance use disorders or neuropsychiatric conditions may also require appropriate medical attention in order to achieve sustained recovery.

**Future Research** As noted earlier in this chapter, there is robust evidence for the efficacy of twelve-step programs and twelve-step facilitation for alcohol dependence/alcohol use disorders. Much less is known for the efficacy and effectiveness of TS/TSF for other types of substance use disorders, although preliminary findings are promising [6]. Also, the generalizability of findings for diverse populations is largely unknown. For example, there is a paucity of research on the usefulness of twelve-step groups for adolescents and young adults, and those with various ethnicities and incomes [26]. We are not aware of research that specifically has studied recovery groups that integrate Christianity with twelve-step principles, such as Celebrate Recovery. In conclusion, interdisciplinary research done by cognitive scientists, psychologists, and scientists from other disciplines that examines the factors that mediate twelve-step recovery could improve the effectiveness of twelve-step-based therapies [27]. Interdisciplinary research in each of the above areas is needed to better understand which recovery groups are likely to help promote recovery and flourishing for the diverse individuals and populations that we treat who struggle with addictions.

## Appendix

**How to Do TSF?** Due to space limitations, we refer interested clinicians seeking practical guidance on how to do TSF to the Project COMBINE Cognitive Behavioral Therapy manual [28]. Briefly, the steps include:

- Provide a rationale for mutual-support group involvement.
- Ask your patient for the reasons why additional support could be helpful.
- Explore said patients' attitudes and beliefs about mutual support.

- Give information about available groups.
- Give practical information on what to expect in a recovery group.
- Encourage sampling more than one group; provide referral information.
- Make a specific action plan.

For more detailed information, please refer to the above-referenced CBT manual.

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# Chapter 12
# Models of Integration of Christian Worldview and Psychiatry


**Gerrit Glas**

## Introduction

From a historical point of view, the process of modernization of our society has led not only to increasing division of labor but also to ongoing specialization of the sciences and the professions rooted in them. This specialization has been accompanied by loosening of the ties between the professions and the worldviews that inspired them. Professionals became experts that should be trusted because of the expert role they fulfill and not on the basis of their moral convictions or religious inspiration. Secularization of the professions seems, in short, the necessary counterpart of modernization [5, 41]. This picture of the history of the growth of science and professional practices has been influential. It shaped, for instance, the discussion about the relationship between Christianity and psychology (and, as a result, psychiatry) in the USA, a discussion that is known as the "integration" debate. The discussion became a story about lost territory and about what to do about it [13, 27, 28]. The implicit assumption is that the sciences make religion irrelevant for the understanding of their object and, that, consequently, practices that are based on the sciences should be seen as separate from any religious, spiritual, and personal input.

My work as psychiatrist can be seen as a struggle against this assumption. The assumption was also an important reason for studying philosophy. Philosophy helped me organize my mind. It enabled me to make a distinction between different kinds of knowing, without giving up the idea of an inner connection among worldview, theory, and professional practice.

To begin with, let us start with the one-sided picture of the rise of professionalism, I just gave. This picture is based on a positivistic idea of science which views science as the source of neutral, objective, and value-free knowledge. For many

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decades philosophers have rejected this view and argued for much more nuanced positions. Sociologists, moreover, have shown that professionalism entails more than exerting the expert role. The expert role is embedded in what sociologists call a societal contract, i.e., an agreement between stakeholders such as patients, professionals, the government, civil parties, insurance companies, the legal system, and so on [1, 6, 14, 16, 21–23, 40, 43]. The contract provides the legitimacy, ethical basis, and boundaries for the provision of healthcare. The very idea of a societal contract implies that stakeholders negotiate about what is important for them. There is, in other words, a second reason why professionalism is not neutral. It is not only not neutral because science is not neutral but also because of the value-ladenness of the contract on which professionalism is based. The contract is the outcome of a struggle about interests and stakeholder values. These values form the very heart of the contract and are the basis of professionalism. Consider, for instance, the role of core values like beneficence, justice, autonomy, and well-being in healthcare. Worldviews and religiously inspired ideals are obviously important sources for the articulation of such values.

In this chapter the debate about the relationship between psychiatry and Christianity will be reviewed from a conceptual point of view. First, different approaches to the integration debate in the USA will be sketched. This sketch will be followed by a brief analysis of the underlying epistemic and conceptual assumptions of the debate. A distinction will be introduced between different forms of knowing, especially between scientific and professional knowing. Then the focus will shift to the practical and societal context in which professional knowledge unfolds. I will introduce a normative practice approach (NPA) to psychiatry and highlight how this approach may give a new twist to the more classical integration debate.

## The "Integration" Debate

The integration movement came in three waves, the first arising toward the end of the 1950s and early 1960s, with work by Paul Meehl, Paul Tournier, Richard Bube, and Gary Collins. Next, the discussion took a direction that was shaped by the establishment of two graduate schools (Fuller and Rosemead, both in California) and the publication of two journals, the *Journal of Psychology and Theology* and the *Journal of Psychology and Christianity*. During the 1990s a third wave brought renewed interest in the issue, partially as a spin-off of empirical research at the boundaries of religion and psychology/psychiatry. The emphasis of this research was, among others, on topics such as forgiveness and religious coping. In what follows in this chapter, I will review earlier attempts at classification by briefly discussing nine models of integration, six of them focusing on psychology (including counseling and psychotherapy) and three on psychiatry [3, 13, 24–27, 30]; see [4] for an impression of the debate in other fields.

## Models of Integration in Psychology

1. One early attempt is known as the *biblical counseling* model. This model holds that the (Christian) believer already knows the full truth and that psychology as a science can only provide a limited and hazy shadow of this truth. The model uses a very broad and unusual definition of psychology. Psychology is the human psyche (i.e., the sum of psychological phenomena) and simultaneously the totality of psychological theories. The model also involves the practice or application of these theories in various professional contexts as well as the institutional context in which this happens, i.e., the totality of organizations, jurisprudence, and financial processes that allow the professional to do his work [33]. The Bible presents a form of psychology in this view. Powlison refers to this psychology as "faith's psychology." It is the sum of views on man and the role of humankind in this world that is presented by the Scriptures. The belief is that the science of psychology cannot and will not provide insights that were not already known from the Bible more profoundly and radically.
2. According to the *levels of explanation* model, science and religion belong to different levels, or kinds, of understanding. As a result, there is not – and cannot be – a battle between Christian religion and science. David Myers, social psychologist and defender of this position, holds that religion and science are different in kind, but nevertheless mutually connected by the awareness of humility, wonder, and awe. This awareness colors both religious experience and scientific experience. Science and religious belief influence each other [32]. Scientists with a Christian background will look for harmony with and confirmation of their basic convictions, for example, about human nature. They seek to learn about the determinants of religious experience and about the effects of religion. Or, they may see a convergence between biblical teaching and psychological research on self-esteem and self-serving bias, i.e., the tendency to present oneself as better than one is. These notions support the Christian belief that humans are inclined to self-justification and pride. Christians may also be struck by what appears to be a divergence between the research findings of science and their beliefs. Myers mentions, for example, the double-blinded studies on distant intercessory prayer (DIP). The results of DIP, for instance, on rheumatoid arthritis or bypass surgery outcomes have been unimpressive. Here, science may lead to reconsideration of one's theological views. Maybe, the scientific hypothesis on which this research is based proceeds from a theologically incorrect understanding of prayer, as if it were a kind of magic. So, there are cases in which correct scientific findings may lead to legitimate questions about one's theology. At the most fundamental level, according to this model, science will never threaten the deepest truths of Christian religion. This is because scientific methods are restricted to aspects of natural phenomena that can be observed and measured and their relevant "levels" of explanation, whereas Christianity appeals to the world as a whole from the perspective of faith.

3. The *integration* approach of Collins [8] and Jones [28] aims at the application of biblical insights in psychotherapy, counseling, pastoral work, youth and family care, and social work. Collins, author of at least 40 books on the relationship between psychology and Christian faith and co-founder of the influential American Association of Christian Counselors (AACC), suggests that more emphasis should be put on the practical, instead of theoretical, needs of counselors and psychotherapists. After years of theoretical discussion, this model argues that it is time to grasp the relationship between Christian belief and psychology in a holistic manner. The way to integrate the two depends on the situation, on the person, and on the specific characteristics of the issue at stake. Integration is plural, personal, indefinable, hermeneutically solid, eschatologically and culturally sensitive. It is plural because in an academic/scientific context, integration means something different than in a counseling context. It is personal, because the shape of a given integration attempt is always determined by character, personal development, and context. Integration is indefinable because of the personal touch and the many different meanings that terms such as faith, belief, and religion may have. Integration requires that one's hermeneutics is solid. Exegetical choices need to be clear, and interpretations should initially be taken as provisional. This openness is enhanced by viewing counseling and psychotherapy from an eschatological (future-oriented) perspective. This future-orientedness means that the lives of one's clients are not only determined by character and psychopathology but are always open to the work of the Holy Spirit. Unexpected and hopeful things may occur, and therapists should be ready to recognize and value them. Integration attempts, finally, ought to be culturally sensitive. Solutions inspired by one's own religious point of view do not fit every context equally well. Strong family ties and emphasis on solidarity among Asians may, for instance, be at odds with the focus on individuality that is characteristic for counseling techniques in the Western world. It may, under the current circumstances, even be better to leave the term integration and to speak of joining forces. Joining implies respect for the identity of the parties involved. It puts emphasis on cooperation.
4. According to the *Christian psychology view*, the integration debate proceeds from an established and rather limited idea about what psychology is. This idea needs critical questioning, according to philosopher Robert C. Roberts [36]. Academic psychology is positivistic and scientistic. It accepts as true only that which science can prove through observation and experiment and leaves no room for other ways of knowing and other routes to truth, like Christian faith. What is needed is a critical investigation of the presuppositions of academic psychology and of the views on which psychotherapeutic methods are based. Without such criticism, attempts at integration will lead to contamination. Science will pollute and weaken authentic Christian insight. And the proliferation of the scientific point of view will finally seduce Christians to adapt to underlying non-Christian convictions. The other option, juxtaposition, puts psychology and Christianity next to one another, without any meaningful interaction between the two. This option is also unattractive because it would deny

Christianity any relevance whatsoever for psychology (or vice versa). There is a third way, however, beyond integration and juxtaposition. This way aims at a new, radically different start of psychology itself. This so-called Christian psychology begins with Desert Fathers such as John Cassian and Evagrius Ponticus, and proceeds with great Christian thinkers and theologians like Augustin, Aquinas, Luther, Pascal, Kierkegaard, Baxter, Edwards, and Dostoyevsky. Roberts aims at preserving what psychology has delivered by measuring and explaining emotions, perceptions, behaviors, and the like. But psychology should also address the purpose of life and the existential concerns humans have. The Christian authors just mentioned did not distinguish their faith from psychology. Christian academics and professionals today are facing a different situation. They should not abolish psychology but turn it into something different, by purifying and preserving the Christian element in the psychology of the thinkers and theologians just mentioned, and by translating this Christian content into a form that contemporaries can understand. Roberts opposes superficial attempts at accommodation. The Christian psychology view is no less radical than Powlison's biblical counseling model. But it focuses much more on saving what is good in academic psychology. It is also more explicit about what needs to be preserved from the Christian tradition, especially the tradition of spiritual exercise and mystic contemplation.

5. The fifth approach is known as the *transformation view*. It argues for a "spiritual-emotional transformation of the psychologist as the foundation for understanding, developing and preserving the (1) process, (2) methodology and (3) product of doing psychology" [7, p. 200]. This view is less a model of relating psychology to Christian faith and more a transformation of psychology itself, as a science, into a different form of knowing, a form of knowing that is "intrinsically a single act of faith and love." The idea is that instead of clinging to a reductive and naturalistic view of the human person, the psychologist's eyes need to be opened to recognize the spiritual, ethical, and immaterial aspects of the client's existence as well as her own. This requires nothing less than a conversion, a spiritual-emotional transformation, that enables the psychologist to experience "Christian realities" (p. 206). By doing so the psychologist comes to love "God in the object of science and the object of science in God" (p. 207). Doing so implies that there exists an external world with lawlike dynamical structures. These structures can be known "for the sake of wisdom" (with a reference to wisdom literature in the Bible). There are also realities that are known by faith. Knowledge of the external world and knowledge by faith are united in a single vision of love in understanding the person (p. 223). Even the destruction of traditional science by the Christian psychology view does not go far enough, according to Coe and Hall (p. 189). The transformation model, on the other hand, does not offer a clear methodology of how to achieve integration.
6. Entwistle [13] sees the relationship between psychology and Christianity as a relationship between *allies.* He does not promote one solution for the many facets of the integration debate. There are many debates and there are many ways to search for integration. He identifies one-sidedness in several of the approaches

that were discussed earlier. Adherents of Biblical psychology, for instance, behave like "colonialists" by occupying foreign space (psychology) and incorporating what fits within their own worldview. Christian psychologists are "rebuilders"; they start afresh and try to build a new house. Proponents of the levels of analysis approach consider psychology and Christianity as "neutral parties" (for an overview, see ibidem, p. 186). There are also "spies," i.e., professionals who use a watered-down version of religion for their own purposes, as well as "enemies," i.e., those who see psychology and Christianity as completely opposite. The ally metaphor is flexible enough to cover different forms and routes to integration. Attempts at integration (or, at least, coherence) may take place at the level of worldviews, of presuppositions (foundations), between disciplines, within disciplines, in the application of certain insights in more practical contexts, at a public and communal level, and within the professional as person. It is this latter form of integration that is deemed to be most important.

## Integration Debates in Psychiatry

So far, we have discussed the integration debate in psychology. But how about psychiatry? In spite of the increasing empirical study of religion and spirituality (R/S) in the context of psychiatry, there has very little been written from a conceptual point of view. Balboni, Peteet, and Puchalski [3] are an exception; see also [2, 10]. They describe three "models of integration," which each put emphasis on different aspects of the intersection between R/S and psychiatric practice.

7. The *whole-person model* builds on the WHO definition of health and the interprofessional model of spiritual care [34]. It develops a biopsychosocial-spiritual model of care [38] and sees it as an obligation of every professional to attend to the whole person. This approach considers religious and spiritual concerns as a domain of care in its own right, requiring expertise which is as specialized as the expertise that is needed for other domains. It implies teamwork, given the diversity in expertise between professions. It argues that chaplains, as spiritual caregivers, should be fully integrated into the team, entailing a view of medical care which puts emphasis on healing, which goes further than curing. The notion of healing aims at wholeness and meaningfulness and at the relation between physician and patient which, ideally, should be characterized by authenticity, compassion, vulnerability, and awareness of the transformative potential of the clinical encounter.
8. The *existential functioning model* requires clinicians to attend to existential themes in the lives of their patients. Examples of these themes are hope, identity, meaning/purpose, morality, and autonomy/authority. These themes may become important because of underlying spiritual distress. Religiously inspired guilt feelings may erode one's self-confidence and hope. But lack of hope and lack of self-confidence may also give rise to spiritual distress. So, in short, this model

sees no sharp division between problems that are caused by an illness and problems that are caused by moral or religious wrongdoings.

9. The last model is marked by *open pluralism*. This model puts emphasis on the larger cultural and institutional contexts in which mental healthcare is delivered, including the values and ideas that are inherent to these contexts. These contexts and spheres have their own normative anchor points, each with their own plausibility structure. The term plausibility structure is adopted from the work of sociologist Peter Berger [5], who argued that as a result of the process of division of labor, there has emerged a plurality of social spheres, each having its own set of values and arguments to explain and justify its existence and its relation to other social structures and institutions. The process of division of labor consist of "repeating and overlapping patterns of bifurcations" which finally have resulted in the dichotomizing between the spiritual and the non-spiritual. The current separation of spirituality and medicine is, therefore, not so much the result of developments within medicine itself. It is rooted in a larger historical and social process that has led to a division of tasks and, finally, to noncommunication between professionals working in the fields of medicine, psychology, and spiritual care. Adherents of the open-plurality model argue that this should not be the endpoint and that there are other constructions of social reality possible, especially in open and plural societies. Hospitals and other care facilities are realities which are rooted in cultures and communities which may perceive spirituality as interwoven with every aspect of human life. A fully developed pluralist approach would welcome spiritual traditions expressing themselves on a social and institutional level, i.e., in the practice of medicine itself (see also [9]).

One of the insights of the open-plurality view is that it points to the limitations of therapeutic neutrality, i.e., the view that considers separation between the medical and the spiritual as the default position. The historical process leading to the separation between medicine and spirituality is not self-evident, however. Nor is it neutral. The very fact of the separation between these fields construes its own reality, i.e., a reality in which professionals view religion and spirituality as outside their scope of competence and interest, and in which they tend to abstain from personal engagement with these issues in the consulting room. The open pluralism approach helps to show that the neutrality option is not neutral itself, i.e., that it is one among many other value-laden views on professionalism.

## Epistemic Distinctions

One notable and intriguing aspect of the discussion above is the lack of consensus about what psychology and psychiatry are. Myers and Entwistle are among the few scholars who deal with what one would normally call psychology, that is, the study of mental phenomena as practiced in laboratories and other research contexts, where results are (re)produced and published in scientific journals and handbooks (see for

another example [12]). Other authors tend to be dismissive of psychology (the biblical counseling view), are more interested in counseling and practical integration (integration approach), or aim at their own broad mix of worldview, theology, psychological theory (Christian psychology), and even personality building (transformation view).

Behind this lack of consensus on what psychology might be lies disregard for the epistemic distinctions among philosophical insight, scientific analysis (which includes theological research), professional knowledge, and everyday understanding. One can indeed, as Collins suggests, attribute the difference between the approaches to the variety of contexts in which the debate is situated: academic, educational, pastoral, psychotherapeutic, or in the context of counseling. However, most authors, with the exception of Entwistle, leave it at that. None of them articulates how contexts shape knowledge or analyzes the role of different types of knowledge in each of these contexts. However, such analysis is indispensable if the discussion is to move forward.

Table 12.1 provides an example of how the epistemic distinctions could be drawn. The table suggests that the ways of knowing of philosophers, scientists, professionals, and laypeople differ in a significant way. *Scientists* analyze things. They focus on specific aspects or features of a thing: the motion of an electron (kinematic aspect), the physiological manifestation of emotion (biological aspect), or the social dynamic of groups (social aspect). They set this aspect apart, artificially, by focusing on how particular features of a process or thing can be explained (abstraction). They try to unravel regularities, patterns, and/or lawlike relations that hold for these features. Scientists (at least quantitative researchers) are usually not interested in individual cases but in general patterns (regularities, lawlike relations, rules). *Clinicians* think differently, and their knowledge is differently structured. They focus on the individual patient and try to make sense of all possibly relevant pieces of scientific knowledge in the context of the individual person [31, 37]. For the scientist, precise and accurate analysis of a specific aspect of an object is important. The clinician is interested in the relation between specific observations and the bigger picture. The patterns and lawlike relations that are at the center of the scientist's mind have a validity that generalizes over many cases of a given kind. Clinical knowledge, however, aims at characteristic patterns that embrace heterogeneous phenomena in one patient. The weighing of the relevance of scientific evidence in individual cases requires clinical experience and "tacit knowledge" [17]. This experience is much more than a collection of facts, stories, and constellations of

**Table 12.1** Levels of knowing and understanding

| | |
|---|---|
| Philosophical assumptions | Paradigms, core concepts, boundary questions |
| Scientific knowledge | General knowledge about lawful aspects of things/events |
| Clinical knowledge | Experiential, pattern-like, and often tacit knowledge about (types of) individuals |
| Everyday experience and knowledge | Holistic, coherent |

symptoms in the clinician's mind. It is a capacity to order different aspects into a coherent, multidimensional picture, with a foreground and a background, and a time dimension.

*Philosophers* aim at still another type of knowledge. They are interested in underlying general ideas, core concepts, and paradigms. They investigate the influence of presuppositions and basic assumptions on empirical research and theory formation. They analyze the logical structure of arguments. They investigate and reveal boundary questions, i.e., questions in a scientific domain that are fundamental and cannot be evaded, nor answered, with the resources available in that domain.

*Everyday experience* and *knowledge*, finally, are holistic, global, and often somewhat imprecise.

What do these distinctions mean for the "integration" debate? There are two aspects that need to be highlighted. One implication is that the relation between religion and psychology should be addressed at different levels. Entwistle suggests something similar. At the level of philosophy, there exists a battle between paradigms, for instance between scientistic/positivistic and open/pluralistic approaches to science. At the level of science, one may discern the often-implicit influence of worldview-related issues on the choice of hypotheses, theoretical assumptions, explanatory frameworks, and their translation to nonscientific contexts. At the level of clinical/professional knowledge, religion and religiously based convictions may have an impact on how professionals conceive their jobs and relate to their patients. And at the level of everyday understanding, there is the influence of one's life and worldview on how one interprets one's symptoms and on how one appreciates what science may mean for oneself as lay person.

A second, related point is that the influence of religious worldviews does not (only) occur top-down, i.e., from philosophical assumptions via theories into professional practices, but in different directions, i.e., also bottom-up and within a given level. Even in cases in which there is top-down influence, this should not be considered as a deterministic force but as an influencing factor that should be investigated given its possible implications. To give an example, even if it is true that Freud embraced atheism (worldview) and that Freudian psychoanalysis supports a naturalistic and tragic view on man (philosophy), this does not imply that every psychoanalyst has to endorse a naturalist view on man and will turn into an atheist while practicing psychoanalysis (influence of philosophy via theory on one's professional stance as therapist). There are many successful psychoanalysts who maintain other than atheist and naturalist worldviews. It is true that psychoanalysis has a reputation of being atheistic and reductionistic. But a total rejection of psychoanalysis and psychoanalytic theory for this reason would imply a disregard of the epistemic differences between religion, philosophical presuppositions, scientific theories, and professional knowledge. Hypotheses need to be testable. They are educated guesses about an aspect of an object. For psychoanalysis, it has, at least for a long time, proven to be problematic to formulate testable hypotheses. As a result, theory and worldview could easily merge in the psychoanalytic mind. But that is a weakness of psychoanalysis and not a necessary consequence of being trained in psychoanalytic theory.

Similarly, this applies to neurobiology. Today's neuroscience has successfully unraveled numerous neural processes that are involved in psychopathological states. But the explanatory relevance of neurobiological knowledge is still a matter of discussion for much of what we know about psychiatric conditions. The philosophically fundamental point is that even if we were to have a complete knowledge of all neurobiological aspects of human behavior, this still would only explain the neurobiological principles that undergird human behavior, not the psychological, social, and moral principles that are also relevant for the understanding of human behavior.

There are philosophers who disagree with this. But these scholars face the difficult task of having to choose among three not so attractive solutions:

(a) Either to simply deny the relevance of these higher-order (psychological, social, and moral) principles for the understanding of human behavior (*classical reductionism;* this approach does not solve but rather eradicates the problem)
(b) To suppose that at a critical level of neurobiological complexity "new" phenomena will emerge, with their own regularities and lawfulness (which can be captured in psychological or social terms) (*emergentism* or *emergence view*; this approach is often described as speculative)
(c) To uncritically expand the boundaries of neurobiology by adopting terms that strictly speaking refer to other than neurobiological domains (*uncritical eclecticism*; this approach does not solve the problem)

In short, science never encompasses and defines a phenomenon in its totality, i.e., as a whole, but only aspects of it. Sciences that claim to have found what a certain phenomenon "really is" run the risk of being reductionistic. It is important to maintain a clear idea about the distinction between (legitimate) reduction and reductionism. When the distinctions among science, philosophy, and worldview are not taken into account, worldviews will become mixed with science, which will lead either to a scientism that allows scientific insights to adopt the place of worldviews, or to the wrongful use of science by considering it as proof of one's worldview, or to rejection of science altogether because it embraces the "wrong" worldview.

## Application to the Integration Debate

The account elaborated here does not imply a harmless and peaceful coexistence between worldview and science. Worldview, science, and professionalism influence one another in many ways, not only top-down, but also and more frequently at the same level (within a given scientific or professional community) and bottom-up (from one's everyday understanding to professionalism and scientific thinking). When worldviews or scientific insights are extrapolated to other domains, there may arise tensions and incoherence. These tensions and incoherence point at possible implications, not necessarily logical conclusions. They, moreover, cannot be solved by a super-science, for instance, a mix of philosophy and worldview that overarches both worldviews and science. We simply do not possess the epistemic power to

develop such encompassing forms of knowledge. Scientists are not able to escape from the necessary limitations of the theoretical attitude of thought, whereas in our everyday understanding, we lack the power of intuiting what goes on beneath the surface, in terms of molecular processes or astrophysical events. Worldviews aim at the whole, but do not offer a viewpoint beyond all other viewpoints. They aim at different "deeper," invisible, and/or transcendent aspects of the world we inhabit, aspects that require an attitude of wonder and awe.

For professionalism, it seems plausible to suppose that the ethics, values, and general outlook on one's professional role are primarily encoded horizontally, by day-to-day interactions with supervisors and other role models; by teaching and education; by participating in clinical rounds, consultations, audits, and the like; and by becoming part of professional life in one's institution. All these influences together are reflected and (re)negotiated time and again, in the definition of one's professional identity and in formulations about professional goals and standards of excellence.

Apart from these interactions at the working floor, individual psychiatrists may work on the basis of a particular worldview or concept of man. These concepts are reflected in one's preferences and one's stance with respect to the central questions of psychiatry. To mention two examples, preference for a neuroscience-oriented pharmacological approach may reflect a more naturalistic conception of man and of the relationship between mind and the brain, whereas the critical approach of social and ecological perspectives on psychiatry can be seen as a reflection of a relational and contextual view of who we are.

## Use of Psychopharmacological Agents as a Case Example

Let me clarify the above with an example: the use of psychopharmacological agents in psychiatry. What I aim to show is how worldview-related concerns, values, and assumptions about the human condition play a role at different levels of understanding of how psychopharmacological agents might work. At the level of everyday experience and dealing with illness, the use of such agents may evoke different responses. Many patients feel resistance because the use of something chemical means that it is "not natural." Others feel that they will lose control over themselves. Still others are relieved to hear that they have a common disorder and can do something about what is happening. Then again, there are those who associate the use of psychopharmacological agents with industrialism and a capitalist society, which pushes people to the extreme and calls the pill industry into life to discipline people in the rat race that modern society is in many respects. The suggestion to use psychopharmacological agents may evoke a wide range of reactions, all of which in one way or another interact with an underlying idea about "the good life." It is superfluous to say that religion is a preeminent provider of ideas of what a good life is and could be.

Professionals are dealing with the patient's interpretation of what they as experts propose. Ideally this is a part of the practice of "shared decision-making" and of

what Fulford and others have called “values-based practice” [15, 42]. It is crucial for professionals to learn to discern between their expert opinion and their personal views. More specifically they need to know to which degree their expert opinion is based on scientific evidence and whether and to what extent there is room for other interpretations. One of the obvious traps for professionals is to think that something is good to do because it follows from one’s expert judgment. Clinicians run the risk of seeing the patient as primarily the object of application of scientific insights. The point is that relevance is a multifaceted quality. Within a scientific context, the relevance of scientific evidence can be clarified by the use of statistical techniques (Bayesian statistics, for instance), by excluding confounders, by discerning mediating and moderating factors, and the like. But relevance in the clinical domain involves many other aspects. In the end, there is always the patient who has to decide – in dialogue with the clinician – whether the proposed (pharmacological) treatment is relevant (important, valuable) enough for her, in the context of her life, with all the issues that may also (legitimately or not) affect the choice she has to make.

It is sometimes difficult to draw the line between one’s expert and one’s personal views as a professional in such cases. There is a fine line between legitimately contradicting erroneous conceptions of patients about how pills work and exerting undue pressure in whatsoever subtle form to let patients do what one thinks is best. Seeing the patient as a whole person, and not as merely object of the application of techniques, skills, and knowledge, builds on one’s own convictions as a person.

There is a distinction between who one is as person and who one is while performing the professional role. This distinction seems obvious. It is nevertheless difficult to deal with it, especially in cases in which patients refuse or obstruct the care that doctors deem to be vital. It is sometimes possible to address this difficulty by changing hats, for instance by saying, “This is what I must say as a professional, but when I talk with you as a person who has some experience with the concerns you are talking about, I can see your point. However, there is also a downside to what you say…” et cetera. One may use more subtle language and strive to develop the disagreement into an exchange of views on underlying values and concerns, for instance, by thinking aloud and conveying one’s inner dialogue as clinician, i.e., the dialogue between oneself as expert and oneself as person with a biography of his own. This may evolve into a kind of role playing in which one switches roles between oneself as professional, oneself as person, and the patient with her resistance and arguments against medication. One may even use another person as representative of the patient.

## Psychiatry as Normative Practice

Elsewhere [19–21] I have explained how, at the clinical level of understanding, it may be helpful to consider medical (psychiatric) practice as a normative practice, i.e., as a practice that is not governed by external rules and norms but by rules and

norms that are intrinsic to and constitutive for that practice. It is helpful to distinguish in this context between three fundamentally distinct types of norms, i.e., between constitutive, conditioning (or conditions defining/enabling), and qualifying norms (principles, rules). *Constitutive* for medical practice are medical knowledge and skills. They form as it were the foundation for medical practice. *Conditioning* norms, principles, and roles shape the economic, institutional, and legal conditions under which doctors, nurses, and other healthcare professionals perform their practices. *Qualifying* norms are those norms, rules, and principles that are typical prerequisites for a practice to be called medical (or psychiatric). Beneficence (doing well to the patient) is often mentioned as a typical qualifying norm for medical practice: the demand to focus first and foremost on the well-being of the patient, which reflects a moral standard.

The normative practice approach (NPA) provides an elementary conceptual framework that helps to identify role reversal between norms of different types [21; Chap. 6]. Many of the problems in current healthcare, psychiatry included, can be elucidated and analyzed by using this framework (more about this later). Another benefit of NPA is that it sees norms, rules, and principles that hold for medical and other practices as intrinsic. They are not foreign intrusions but necessary constituents for a given practice. Without them the practice would not exist and fall into decay. Worldviews and religious or spiritual insights influence the general orientation and the ethos of a practice, i.e., they determine, so to speak, the direction of a practice. The norms and principles of NPA define the (norm-responsive) structure of a practice. The NPA gives an answer to the Weberian idea of the inner secularization of professional practices that was briefly alluded to in the introduction. It suggests that these practices are driven by the purposes and goods that are inherent to them. For this reason, these practices are by definition not neutral or merely instrumental for these purposes. Goods are internal to practices. This statement, famously phrased by Alasdair MacIntyre in his *After Virtue* [29], forms the background of NPA. Herman Dooyeweerd's systematic philosophy, with its distinctions between different forms of normativity and their distinct roles (qualifying, conditioning, constitutive), has inspired the structural analysis that lies at the basis of the approach [11; Vol. 1]. Generally, the approach is compatible with a communitarian approach in social philosophy and ethics [39] and with the recent revival of virtue ethics and recognition of its importance for character building in professional education [35].

As recent developments in medicine and psychiatry have shown, things go wrong when constitutive or conditioning norms and principles fulfill the role of qualifying norms. Examples are authoritarian and paternalistic approaches to the physician's role and excessive market-driven scenario's for healthcare improvement. The switching of roles between foundational and qualifying principles lies at the basis of the authoritarian and paternalistic perspective on the physician's role. What science determines about the patient is thought to represent the truth for the patient. Therefore, the doctor, as messenger of this truth, conceives himself as speaking with authority. He thinks he knows what is best for the patient. He conceives of himself not just as the expert on scientific content (which is no problem) but also about what is good for the patient. The authoritarian approach presupposes an absolutization of

the expert role. The expert role is only constitutive, however. It does not tell what is good for the patient. It contributes in an important way to the patient's considerations about what is good. But ultimately this judgment should be viewed in the light of other relevant factors. Doing well for the patient means adjusting one's treatment suggestions to the world and the level of understanding of the patient and her context, exploring the expectations and views of the patient, and trying to engage in a meaningful exchange of opinions about pros and cons of a given treatment. This is, again, what is meant by shared decision-making.

Another example can be found in the excessive market-driven healthcare reforms. These reforms are an example of role reversal between conditioning and qualifying norms and principles. In these scenarios, good doctors are the ones who best obey the principles of efficiency and frugality. These are economic notions, however. When they adopt the place of the qualifying (ethical) principles, they excavate the moral core of medical practice. The model depicted in Fig. 12.1 might be helpful to structure our thinking about what is meant here. It gives a sketch of how the affective, reflexive, and morally sensitive attuning to the needs of the patient might be conceived, i.e., as embedded in relations, both to the patient and to oneself. Attuning to the needs of the patient implies always that one attunes to one's own role in all the different contexts. This attuning implies a constant balancing and interaction between one's own basic commitments and concerns and the role one is expected to fulfill in the specific contexts in which one operates as professional. One could conceive of this attuning as working on one's narrative as professional. The narrative describes one's personal history of enrolling in a profession and of becoming competent, a history that is determined by role models, one's own morality and spirituality, implicit or explicit, and this, again, in the context of larger institutional and societal changes (economic, juridical, social) and of scientific developments.

Figure 12.1 depicts how patients relate to their illness (2), it sketches the influence of contextual influences on the formation and manifestation of illnesses at different levels (individual, institutional, and societal [3]), it highlights how the condition of the patient may contribute to the patient's relation to the illness (4), and it pays attention to the influence of a whole range of person-related factors on how the patient relates to the illness – factors such as character, personal values, biographically determined preoccupations and sensitivities, and ultimate concerns (5). It also sketches the activity of the professional as – ideally – focused on all these five issues/themes (A) and as related to a multilayered context (C), which itself influences all other relations. Relation (B) indicates that the professional as person relates to her own role. This self-relating as professional is in turn influenced by one's factual role fulfillment (D) and by person-related factors like personality, biographically determined preoccupations, and sensitivities (E). Moral sensitivity and the capacity to reflect on one's own biases and inclinations belong to the core competences that are required for ethically appropriate behavior. Figure 12.1 highlights that the professional does not coincide with her professional role and is more than a bundle of competencies and skills (for a broader perspective, see also [18, 35]). The neutrality thesis, which as we saw leads to a separation between the fields of psychiatry and R/S, is not self-evident, nor the only tenable position in an era which

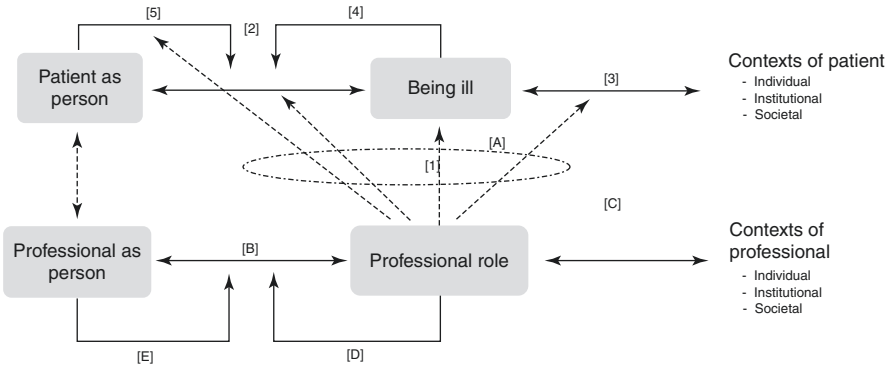


**Fig. 12.1** Attuning to the patient and to one's role as professional
*In his/her professional role, the professional pays attention to different aspects of being ill [1–5]*
**1. Professional focuses on manifestations of illness**
**2. Interaction between patient and illness**
**3. Interaction between context and illness**
**4. Influence of being ill on the way the patient deals with the disorder**
**5. Influence of the person on the way the patient deals with being ill**
*In his/her professional role, the professional relates in different ways to his/her own professional role fulfillment [A–E]***:**
**A. Professional role in its fullest sense**
**B. Attitude toward and dealing with professional role**
**C. Interaction professional role – context**
**D. Influence professional role on attitude toward professional role**
**E. Influence person on attitude toward professional role**

puts emphasis on evidence and a solid scientific basis. The neutrality position is itself an expression of a particular stance toward professional role fulfillment, i.e., a stance that considers personal involvement only relevant in so far it sustains the scientific integrity of professional work. The side effect of this stance is that the subjective reactions of the patient to his illness are considered as only relevant in so far they can be accounted for in terms that fit the science-based conceptual framework of the psychiatrist.

## Conclusion

Is there a future for fruitful interaction and exchange between Christianity and psychiatry? I think there is. Breaking the spell of Weber's secularization thesis is a prerequisite. However, as we have shown in different ways, secularization is not inherent to the process of modernization, with its increasing division of labor, specialization, and need for bureaucratic control.

We have seen that worldviews are no foreign intruders for professionalism but play a subtle and important role in negotiations about the social contract on which psychiatric professionalism is based. This especially holds for Christian (and other

theistic) convictions which already for centuries lie at the basis of many of the norms and values that are intrinsic to and important for healthcare. I aim at principles like beneficence, mercifulness, charity, altruism, hope, and trust. The analysis of the conceptual structure of the societal contract amounts to what I have called a normative practice approach (NPA) to psychiatry. This approach sees the norms, values, and principles that guide clinical work as intrinsic to psychiatric practice. Many of the overarching ideals of medical practice are not only in harmony with and but also rooted within the Christian tradition. The Medieval notion of caritas, for instance, has its descendants in today's emphasis on beneficence and altruism as cornerstones for medical ethics.

We have seen that the interaction between worldview and professional practice occurs in many different ways: top-down, bottom-up, and within each of the levels of understanding we discussed (clinical, scientific, philosophical). An atmosphere of openness and responsiveness to the needs of others, together with value sensitivity, will prove to be crucial for the future of psychiatry. There are accounts, philosophical as well as more practical, that do justice to the inherent normativity of clinical (and scientific) practice. The Christian tradition has a rich vocabulary and a wealth of concepts and stories, little and grand, to interpret what is going on in the patient and in healthcare. We as psychiatrists stand just at the beginning of a rediscovery of this wealth.

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# Chapter 13
# Christian-Integrated Psychotherapy


**Harold G. Koenig and Michelle Pearce**

## Background

We begin with a brief review of research examining the relationship between religiosity and mental health in Christian-majority samples, thus helping to justify the integration of Christian beliefs and practices into standard psychotherapies directed at the treatment of emotional disorders. This is followed by a brief review of the evidence on the efficacy of religious/spiritual integrated therapies, and then a focus on studies examining two specific Christian-integrated psychotherapies, Christian religiously-integrated cognitive behavioral therapy (CRCBT) and spiritually integrated Christian cognitive processing therapy (SICPT-C).

**Christianity and Coping** Many Christians utilize religious beliefs and practices to cope with life stressors, loss of loved ones, loss of health, and traumatic life events (natural disasters, epidemics, rape, assault, severe auto accidents). This is not a new phenomenon and, as biblical scriptures demonstrate, has been occurring for at least 2000 years. Traumatic events have always stimulated a surge of religious behaviors directed at relieving the distress that these events cause. For example, after the 9/11

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terrorist attacks on the World Trade Centers in New York City, a random survey of the United States (US) population published in *The New England Journal of Medicine* found 90% of Americans turned to religion to cope with the stress of these events [1]. As documented in 2 editions of the *Handbook of Religion and Health* [2, 3], more than 450 quantitative studies have examined the role that religious/spiritual (R/S) plays in coping with psychological/social stress or physical illness. Of those studies, more than 90% were conducted in Christian-majority samples [4]. Most participants in the studies reported that religion was helpful during these times, sometimes more helpful than many other standard coping resources (family, friends, wealth, etc.). Christian beliefs and practices give meaning to negative life circumstances, provide guidance on how to deal with life stressors, and surround the person with a community of believers who can provide psychological, social, and practical support to prevent or reverse negative emotions.

**Christianity and Negative Emotions** Many cross-sectional, prospective, and experimental studies (including randomized controlled trials, RCTs) have examined the relationship between Christianity and a range of negative emotions within Christian-majority samples. We briefly review here the results for depression, suicide, anxiety, psychosis, and substance use/abuse.

***Depression*** Of the 444 quantitative studies prior to 2010 systematically reviewed in the *Handbooks*, 414 (93%) were conducted in Christian-majority samples. Of those studies, 254 (61%) reported inverse relationships between religious/spiritual (R/S) and depression (including 6 studies at a statistical trend level). In contrast, 26 studies (6%)—mostly cross-sectional in design—reported a significant positive relationship between R/S and greater severity of depression (including 2 at a trend level). There were also 28 clinical trials, of which 17 (61%) found that a R/S intervention (Christian and non-Christian) significantly decreased depressive symptoms compared to standard secular treatments or a control condition, whereas 2 studies (7%) reported that R/S interventions were less effective.

***Suicide*** Our systematic review identified 141 studies that examined the relationship between R/S and suicide (thoughts, attempts, or completed suicide). Of the 141 studies, 126 (90%) were conducted in Christian-majority populations. Of those studies, 99 (79%) found that religiosity was inversely related to suicide, including 4 at a trend level. Two of 126 reported a positive relationship with suicide. Of the 30 studies examining attitudes toward physician-assisted suicide, R/S was significantly and inversely related to positive attitudes in all 30 (100%).

***Anxiety*** Our systematic review identified 299 studies that examined the relationship between R/S and anxiety symptoms. Of those studies, 245 (82%) were conducted in Christian-majority populations. Approximately one half (49%) reported significant inverse relationships between R/S and anxiety (including four at a trend level). In contrast, 24 (10%) found significant positive relationships between greater

anxiety and R/S. Since the overwhelming majority of these studies were cross-sectional in nature, it is not possible to determine if R/S caused less (or more) anxiety, or if anxiety caused less or more R/S. However, anxiety is well known as a stimulator of increased religious devotion ("there are no atheists in foxholes").

***Psychosis*** The relationship between psychosis and R/S within Christianity is more complex, given that psychotic symptoms may include religious delusions of a Christian nature, thus giving the impression that Christian beliefs may be responsible for the psychosis. This is one reason why mental health professionals since the time of Freud tried to isolate psychotic individuals from any religious influences that they thought might exacerbate the psychosis. Of 43 studies published prior to 2010 identified in our systematic review, 39 (88%) were conducted in Christian-majority samples. Among those studies, 11 (28%) found significant inverse relationships with R/S (including 1 at a trend level). In contrast, nine (23%) reported significant positive relationships between R/S and psychotic symptoms (one at a trend level). The remaining studies reported no association.

***Alcohol Use/Abuse*** There is overwhelming evidence that religiously active Christians are less likely to use or abuse alcohol, particularly when younger populations are studied. Our systematic review identified 278 studies that examined the relationship between R/S and alcohol use/abuse, of which 269 (97%) were conducted in Christian-majority samples. Of those, 233 (87%) reported that R/S was inversely related to alcohol use or abuse (11 at a trend level), whereas only 4 studies (1%) reported positive relationships (1 at a trend level).

***Drug Use/Abuse*** Similar findings have been found for drug use and abuse. Our systematic review identified 185 quantitative studies that examined the relationship between R/S and illicit drug use/abuse. Of the 182 studies (98%) conducted in Christian-majority samples, 154 (85%) found significant inverse relationships (including 3 at a trend level). Only two studies (1%) reported a positive relationship between R/S and drug use/abuse.

**Christianity and Positive Emotions** Not only is R/S associated with fewer negative mental and emotional symptoms, it is also associated with greater well-being, life satisfaction, and happiness in Christian-majority populations, along with greater hope, optimism, meaning/purpose, and self-esteem. Perceptions of social support also appear to be greater among those who are more R/S.

***Well-Being*** We identified 326 quantitative studies in our systematic review that examined the relationship between R/S and well-being, most of which (92%) were conducted in Christian-majority samples. Of the 301 studies in Christians, 237 (79%) found that those who were more R/S indicated greater levels of well-being, life satisfaction, or happiness (8 at a trend level). Less than 1% (three studies) reported inverse relationships between R/S and well-being.

***Hope and Optimism*** Of the 40 studies systematically identified that examined the relationship between R/S and hope, 39 were conducted in Christian-majority samples. Of those, 29 (74%) reported significant positive relationships between R/S and hope (2 at a trend level). No studies found inverse relationships. With regard to R/S and optimism, there were 32 studies identified, most (94%) conducted in Christian-majority populations. Of those 30 studies, 25 (83%) reported significant positive relationships with R/S and no studies found inverse relationships.

***Meaning and Purpose*** As noted earlier, an important way that Christianity can affect mental health is by providing meaning and purpose to experiences that occur in life. This is exactly what the research shows. In our earlier systematic review of studies published prior to 2010, 45 examined the relationship between R/S and meaning or purpose in life. All studies but 1 (98%) were conducted in Christian-majority samples, and 41 (93%) of those studies reported significant positive relationships.

***Self-Esteem*** Low self-esteem is strongly related to depression and is closely related to symptoms of worthlessness and being a burden on others. Our systematic review identified 69 studies that examined the relationship between R/S and self-esteem, most of which 65 (94%) were in Christian-majority populations. Of those studies, 40 (62%) reported significantly higher self-esteem among those who were more R/S (not surprisingly, similar to the findings for depression). In contrast, two studies found significantly lower self-esteem among those who were more R/S.

***Social Support*** Finally, given the important role that social support plays in both preventing and recovering from mental health problems, we review research examining the relationship between R/S and receiving emotional support, tangible physical support, and other forms of instrumental support. Among the 74 studies identified in our systematic review, 70 (95%) were in Christian-majority samples. Of those studies, 58 (83%) reported significant positive relationships between R/S and social support, with no studies finding less perceived support among the more R/S.

Thus, from this brief review of largely observational studies in Christian populations, greater religious/spiritual is associated with better mental health in cross-sectional studies and predicts better mental health over time in the majority of longitudinal studies, and among studies included in the above review, religious/spiritual interventions appear to reduce symptoms of distress. Not surprising, then, mental health professionals have begun to integrate clients' Christian beliefs into psychotherapy. A more recent review of this literature continues to support the findings from this earlier systematic review [5].

**Religious/Spiritual Integrated Therapies** The evidence base is also growing rapidly for religious/spiritual integrated therapies (Christian and non-Christian) directed at mental health problems such as depression and anxiety. In the most recent meta-analysis of RCTs in this regard, Captari and colleagues examined the results of 97 outcome studies (the majority targeting depression or psychological

distress) [6]. In this meta-analysis that included 7181 subjects, investigators sought to determine the efficacy of tailoring psychotherapy to clients' R/S beliefs (called "R/S-adapted psychotherapy"). Compared to no treatment, R/S-adapted psychotherapy resulted in a significant overall improvement in clients' negative psychological symptoms (Hedges $g = 0.74$, $p < 0.000$). When compared to secular psychotherapies, effects were likewise superior ($g = 0.33$, $p < 0.001$). In more rigorous "additive" studies, R/S-adapted psychotherapies were equally effective as secular psychotherapies using the same theoretical approach and treatment duration ($g = 0.13$, $p = 0.258$). Effects of R/S-adapted psychotherapies were particularly strong in clients who were more religious at baseline [7], but this has not been found in all studies [8].

**Christian-Integrated Psychotherapies** In a systematic review and meta-analysis of RCTs of interventions that tailored psychotherapies for depression and anxiety to clients' R/S beliefs (called "R/S-adapted psychotherapy"), Anderson and colleagues identified 16 such studies published between 1984 and 2013 [9]. All of these studies used faith-adapted cognitive behavioral therapy (F-CBT). Hedge's g was used to quantify effect sizes, where $g > 0.80$ is considered a large effect. Results were reported for depression and anxiety separately, and by the specific religious approach. For depression, 2 studies (total $n = 44$) were identified that compared Christian F-CBT to control conditions (i.e., wait list, placebo, or treatment as usual). The average post-test ES for these studies was $g = -1.40$ (95% CI = −2.09 to −0.70), indicating a large effect in terms of reducing depressive symptoms. When F-CBT was compared to standard CBT, the average post-test ES achieved by 4 Christian F-CBT studies (total $n = 124$) was $g = -0.59$ (95% CI = −0.95 to −0.23), indicating a moderate to large effect on depressive symptoms. For anxiety as the outcome, since the pre-defined study criteria for these studies were not met, a meta-analysis was not performed. However, when compared to control conditions, the post-test ES for the single study identified of Christian F-CBT ($n = 43$) was $g = -0.79$ (95% CI = −1.42 to −0.17), again indicating a moderate to large effect.

In Captari and colleague's review, the majority of religion-specific adapted psychotherapies ($k = 36$) involved a Christian approach ($k = 28$ studies) [6]. With regard to the relative efficacy of specific faith-based approaches, Captari et al. found that the effects of Christian-adapted psychotherapy were similar to that of Muslim-adapted and general spiritual approaches.

**Examples** To "put a face" on studies of recently conducted R/S-integrated psychotherapy interventions, we now review the results from a study of religious CBT (RCBT) for depression and then describe an ongoing study (results pending) of spiritually integrated cognitive processing therapy (SICPT) for moral injury in the setting of PTSD, which included a Christian-specific version (SICPT-C).

With regard to RCBT, Koenig and colleagues recruited 132 clients with major depressive disorder from southern California and central North Carolina into an RCT examining the effects of religiously integrated CBT ($n = 65$) compared to

conventional CBT ($n = 67$) among clients with chronic medical illness [8]. Five versions of RCBT (Christian, Jewish, Muslim, Buddhist, and Hindu) were developed and manualized by experts in these faith traditions. Given the geographical location of this study in the North Carolina (part of the Bible Belt) and southern California (with a large Hispanic population), 83% of participants in the RCBT group received the Christian version (CRCBT). Thus, these results apply primarily but not exclusively to Christian religiously-integrated CBT. All participants received ten 50-min sessions (94% delivered remotely by telephone) over 12 weeks and were followed up at 4 weeks, 8 weeks, 12 weeks, and 24 weeks.

At the primary endpoint (12 weeks), results indicated that both RCBT and conventional CBT (CCBT) significantly reduced depressive symptoms (Cohen's $d = 3.02$ for RCBT and $d = 2.39$ for CCBT). By the 24-week follow-up, more than half of participants in both groups were in full remission. We initially reported that the effects of RCBT and CCBT on depressive symptoms were similar, but there was a larger effect for RCBT among those who were more religious at baseline [8]. Later reanalysis of the data confirmed no significant overall "group" effect ($B = 0.33$, SE = 1.80, $p = 0.86$) as originally reported or "group by time" effect ($B = 0.54$, SE = 0.64, $p = 0.40$). However, while the "religiosity by group" interaction was significant ($B = –0.09$, SE = 0.03, $p < 0.05$), the "religiosity by group by time" interaction was not ($B = 0.003$, SE = 0.025, $p = 0.88$), indicating that RCBT was not more effective than CCBT when examined over time in those who were more religious (differing from what was initially reported). Other researchers have found that religious/spiritual integrated psychotherapies are more effective among more religious individuals, justifying their use in these patients [7, 10]. Furthermore, religious clients receiving RCBT in the study above were somewhat more likely to comply with the treatment compared to those who were less religious (85.7% vs. 65.9%, $p = 0.10$), justifying the use of RCBT in religious patients. See below for a more detailed description of the Christian religiously-integrated CBT (CRCBT) used in this study.

Concerning SICPT for the treatment of moral injury in the setting of PTSD, a single-group experimental study and a three-arm RCT is currently ongoing to determine the efficacy of this intervention in US Veterans. Standard CPT and prolonged exposure (PE) are the two most common psychological treatments for PTSD in veteran and military populations. SICPT integrates clients' religious and spiritual beliefs using a CPT platform to treat the symptoms of moral injury in the setting of significant PTSD symptoms. SICPT has been developed as a broadly spiritual version and as religions-specific versions in five faith traditions (Christianity, Judaism, Islam, Hinduism, Buddhism). SICPT is currently being field-tested in a single-group intervention study involving 10–15 clients with significant moral injury and PTSD at Duke University Health System [11]. An RCT is also currently underway that involves 60 religious veterans with significant moral injury and PTSD symptoms at the Veterans Administration Greater Los Angeles Healthcare System [12]. Investigators are comparing (a) standard CPT administered by psychologists, (b) SICPT administered by psychologists, and (c) structured pastoral care for moral injury administered by chaplains in this pilot trial. See below for a more detailed description of the Christian version of SICPT used in these two ongoing studies.

## Christian Religiously Integrated Cognitive Behavioral Therapy

Christian religiously-integrated cognitive behavioral therapy (CRCBT) is an empirically validated treatment for depression and anxiety among Christian clients [8, 10, 13–15]. In this section, we will provide a brief description of the treatment and how it differs from standard CBT, the main tools used in CRCBT, and a summary of the ten manualized treatment sessions.

**Description** Standard cognitive behavioral therapy (CBT) is founded on the premise that our thoughts, emotions, and behaviors are all interconnected. According to the theory of CBT, to change a negative emotion, we must change what we are thinking and/or change how we are behaving. As such, CBT therapists teach clients how to change negative thinking styles and maladaptive behaviors to reduce negative emotions and increase positive emotions.

CRCBT is similar to conventional CBT in that it is founded on the same theory and employs the same collaborative, directive, and Socratic style. The difference is that in CRCBT, the client's Christian beliefs, practices, values, teachings, and worldview are explicitly drawn upon to help the client shift negative thinking styles and change unhelpful behaviors. A client's Christian beliefs and resources provide a standard of "truth" against which the client can measure his or her thoughts and actions. In other words, instead of a therapist helping a client to determine what is accurate or helpful, a client looks to their Christian belief system and worldview to help them make this determination. In this way, clients can modify their cognitions and behaviors to line up with what they believe is true, meaningful, and important in life. This value-based approach to therapy provides powerful client-centered incentives for change.

The main tools used in CRCBT are (1) renewing the mind, (2) scripture memorization and contemplative prayer, (3) challenging thoughts using one's religious resources, (4) religious practices, (5) religious resources, and (6) involvement in a religious community. Christians often form their worldview and value system based on teachings from sacred scriptures (i.e., the Bible). For *renewing the mind*, clients are taught the importance of filling their minds with religious scriptures and teachings as a way to replace negative and ruminating thoughts that lead to negative emotions. This tool is based on the Christian scripture that says "Do not conform to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good, pleasing and perfect will" (Romans 12:2).

For *scripture memorization and contemplative prayer*, clients are either provided with a scripture passage from the Bible that is relevant to the session content (see the CRCBT manual for suggestions) or given the option to choose a scripture that is meaningful to them. They are asked to memorize the scripture before the next session. To go even deeper, they are encouraged to meditate on the scripture using a method called contemplative prayer, where they spend dedicated time

reflecting on what the scripture passage means to them and how they can apply it to their lives.

The idea of challenging thoughts is presented to clients as a way to "bring all thoughts captive," an instruction given to believers in the Bible. Clients are taught how to *challenge thoughts using their religious resources* by using the standard CBT "A-B-C-D-E thought log" with an additional step—step R for religious beliefs and practices (A-B-C-D-R-E thought log). Using this revised thought log, clients describe an activating event, their associated beliefs/thoughts, and the consequent emotions and actions stemming from these beliefs. They are also provided with theological reflections on the common unhelpful thinking styles (e.g., all or nothing thinking), which helps clients better understand how these thinking styles might not line up with their religious beliefs and values. Clients are then asked to dispute their unhelpful or inaccurate beliefs with the help of their religious beliefs and resources. They are asked questions such as the following: "When you look at your original belief, expectation, or your way of thinking about the situation, are there any beliefs, teachings, values, or scriptures from your Christian tradition that strike you as helping to generate an alternative viewpoint?" The answers clients derive from these disputing questions will result in an effective new belief and behavioral responses.

Clients are also taught how to engage in various *religious practices* that can help shift their mood. These practices include forgiveness, gratitude, altruism, praying for others, meditation, and so on, each of which has empirical support for reducing depressed mood. Clients are asked to engage in some of these practices on a daily basis. In addition, clients are asked to identify and make use of their *religious resources*. These might include providing or receiving social support from members of their church community, having conversations with their pastor or other church leaders, attending church services, engaging in prayer meetings, listening to worship music, and volunteering.

Finally, clients are encouraged to be *involved in a religious community*. For Christians, this is likely a church community, such as attending church or a church-based small group, such as a Bible study or prayer group. The intention is not just to receive support from this community but to actively provide support to at least one other in this community. Clients are asked to choose one person in the community that they can support and pray for. This is a way for them to live out the Christian commandment to love and care for one another, which also usually results in clients feeling socially supported themselves. Both giving and receiving social support are associated with reduced depression [16, 17].

**Summary of Ten Treatment Sessions** A ten-session treatment manual and accompanying client workbook have been developed for CRCBT to assist when doing therapy with clients who have depression [8]. These materials can be freely accessed online at http://www.spiritualityandhealth.duke.edu/index.php/religious-cbt-study/therapy-manuals. Here we will provide a brief summary of the ten 60-min sessions.

***Session 1: Assessment and Introduction to CRCBT*** In this initial session, clients are oriented to the CRCBT treatment approach and rationale. They learn how to

monitor their mood and activity levels, as well as how replacing negative thoughts with scriptures can be a helpful way to shift their mood. At the end of this sessions (and all sessions), clients are asked to memorize a verse relevant to the session topic before the next session. In addition, at the end of each session, homework is assigned; clients use their CRCBT client workbook to complete the homework.

***Session 2: Behavioral Activation*** In the second session, clients learn how engaging in pleasant activities improves their moods. They are asked to schedule several pleasant activities for the upcoming week. They learn about the biblical principle of "walking by faith" and are asked to engage in activities before they feel like doing so—acting on faith that these activities will help them improve their mood and monitoring the results of their actions.

***Session 3: Identifying Unhelpful Thoughts*** In the third session, clients learn how to identify thoughts that have an impact on their mood. They are introduced to categories of distorted thinking (e.g., catastrophizing, should statements) and are provided with a theological reflection for each category. They then practice the first three steps of a thought log (A-B-C) and are introduced to contemplative prayer.

***Session 4: Changing Unhelpful Thoughts*** In session four, therapists review the association between clients' thoughts and their mood. Clients are then taught the final steps of the thought log (D-R-E), in which they challenge their negative thoughts and replace them with more accurate or helpful thoughts. Therapists emphasize how clients can use their religious beliefs and resources to generate more effective thoughts and how they can use their religious practices to engage in more effective coping responses.

***Session 5: Dealing with Loss*** In the fifth session, clients identify the losses they have experienced as a result of depression (and/or medical illness). These losses include sacred losses—losses that are related to their religious beliefs and relationship with God (e.g., loss of relationships with church members, feeling abandoned by God). They are taught the difference between control and active surrender to God. Therapists encourage clients to rely on their religious resources to give meaning to their losses.

***Session 6: Coping with Spiritual Struggles and Negative Emotions*** In session six, therapists sensitively explore various spiritual struggles that clients may be experiencing (e.g., feeling distant or punished by God). Therapists discuss the meaning of forgiveness and repentance and explore how these tools may assist when coping with spiritual struggles and negative emotions.

***Session 7: Gratitude*** In the seventh session, clients learn about the benefits of gratitude for reducing negative emotions and increasing positive emotions. Clients learn how to engage in both grateful thinking (e.g., making a gratitude list) and grateful behavior (e.g., sending a gratitude letter). An emphasis is placed on religious grati-

tude, including being grateful to God for blessings God has provided and the importance placed on gratitude in Christian teachings.

***Session 8: Altruism*** In the eight session, clients learn about the benefits of being generous and engaging in altruistic acts for reducing negative emotions. The rationale and motivation for altruism are rooted in Christian teachings about loving others. Clients are shown how to plan several altruistic acts and how to monitor their mood before and after engaging in these acts.

***Session 9: Stress-Related and Spiritual Growth*** In session nine, clients learn about the concept of stress-related growth, especially from a Christian perspective. Clients explore ways they may have already experienced positive growth as a result of their experience with depression (or medical illness, if present). They are encouraged to look to their Christian teachings to help them find meaning and purpose in their suffering.

***Session 10: Hope and Relapse Prevention*** In the final session, clients learn how using the cognitive and behavioral strategies in CRCBT can result in the positive emotional state of hope. Clients discuss their progress, goals, and what they have learned in treatment. Therapists review the key skills and CRCBT tools and how to maintain the changes they have achieved.

For clinical case illustrations of how CRCBT is conducted, readers are encouraged to consult the case vignettes in Pearce and Koenig [13] and in Pearce [18].

## Christian Spiritually Integrated Cognitive Processing Therapy

Cognitive processing therapy (CPT) is a manualized treatment for PTSD developed by Patricia Resick and colleagues [19]. SICPT uses a CPT platform to integrate clients' religious and spiritual beliefs into the treatment [20]. Instead of focusing entirely on PTSD, however, SICPT is indicated for anyone who has moral injury in the setting of severe trauma, whether that is from experiences during wartime, those resulting from natural or man-made disasters, rape, or victimization. Likewise, SICPT may be useful for treating moral injury among those caring for individuals who have died or are severely traumatized (first responders, police, firemen, nurses, physicians, and other healthcare professionals), as well as clergy (including missionaries and chaplains) who may experience trauma as a result of the work they do. Because moral injury may serve as a barrier to the effective treatment of PTSD, we believe that moral injury must be addressed first and then PTSD will be much easier to treat using standard approaches. It may even be possible that PTSD symptoms will improve or resolve entirely on their own once moral injury is addressed.

**Description** SICPT was developed for the treatment of US veterans and active-duty military, although it could easily be adapted for other groups as well. As noted above, there is both a Christian-specific version of SICPT and a broader spiritual version of SICPT. The broader spiritual version has many Christian elements but does not rely as heavily on Christian scriptures as does the SICPT-C version. SICPT-C is administered in-person by licensed professional counselors or psychologists who have undergone the required training in CPT. While SICPT-C (as all versions of SICPT) is still under development and being modified as experience with this intervention accumulates from research, there are some general principles that can be summarized. SICPT-C is administered in 12 50-min sessions ideally twice/week over 6 weeks, similar to how standard CPT is conducted. There are no training programs at present for SICPT, although the manual and client workbooks are pretty self-explanatory for clinicians trained in CPT.

**Summary of 12 Treatment Sessions** Here is a brief description of each session as described by Pearce and colleagues [20]. This article also provides an excellent illustration of how to administer SICPT to an individual client.

***Session #1: Introduction: Moral Injury and Rationale for SICPT*** The therapist reviews the symptoms of PTSD and the goals of SICPT, explains the "stuck points" handout, and briefly goes over the traumatic event with the client. For homework ("practice assignment"), clients are asked to write an initial Impact Statement that focuses on the moral injury and its impact on conscience, God, others, and their world.

***Session #2: The Meaning of the Event and Spirituality*** The session begins with the client reading the Impact Statement that they have drafted as homework. The therapist begins to identify stuck points as they apply to moral injury and its impact on spiritual beliefs/practices. The therapist introduces the A-B-C worksheets and explains the relationship between thoughts, feelings, and behavior. For homework, the client is then asked to complete one A-B-C sheet each day and complete the Spiritual Resources worksheet.

***Session #3: Spiritual Resources and Moral Injury*** The therapist reviews the A-B-C and Spiritual Resources worksheets that the client completed as homework. The therapist then introduces the concept of Intention for Kind Attention and Compassion toward moral injury and discusses how this principle fits within the client's spiritual belief system. For homework, the client is asked to continue with the A-B-C worksheets, complete the Core Values worksheet, and read the Prodigal Son story.

***Session #4: Kind Attention and Compassion*** The therapist reviews the A-B-C worksheets on MI that the client completed. The therapist also reviews the concept of setting Intention for Kind Attention and Compassion toward their experiences of moral injury. Dealing with spiritual distress and grief is also addressed. The thera-

pist then introduces spiritually oriented Challenging Questions worksheets to challenge moral injury stuck points. For homework, the client is asked to complete the spiritually oriented Challenging Questions worksheet and to read the worksheet on spiritual reactions to moral injury.

***Session #5: Challenging Questions and Spiritual Distress*** The therapist begins by reviewing the spiritually oriented Challenging Questions worksheet with the client. The therapist also introduces the concept of spiritual distress/grief and lamentation. Time is spent on distinguishing the different types of guilt. The therapist introduces the ritual of confession to deal with guilt. Finally, the Patterns of Problematic Thinking worksheet is discussed. For homework, the client is asked to complete the spiritually oriented Challenging Questions worksheet and choose a confession ritual to practice daily.

***Session #6: Confession Ritual and Problematic Thinking*** The therapist reviews with the client the spiritual confession ritual and Problematic Thinking worksheet completed as homework. Next, the therapist discusses the stages of self, other, and Divine forgiveness, and then introduces the Challenging Beliefs worksheet. For homework, the client is asked to complete the Challenging Beliefs worksheet daily as it relates to forgiving self, others, and God.

***Session #7: Forgiveness I and Challenging Beliefs*** The therapist reviews with the client the completed Challenging Beliefs and Forgiveness worksheets related to forgiveness stuck points. Next, the therapist discusses the REACH forgiveness steps, and ends with an introduction to trust for self, others, and God. For homework, the client is asked to complete the REACH forgiveness worksheets and read the Trust Module.

***Session #8: Trust and Forgiveness II*** The therapist reviews the Challenging Beliefs worksheet regarding forgiveness and trust to identify stuck points. The therapist then discusses "judgment" issues, reviews the REACH forgiveness worksheet, and introduces the concepts of Making Amends, Verbal Blessing, and Esteem for self, others, and God. For homework, the client is asked to complete the Making Amends and Verbal Blessing worksheets and read the Esteem Module.

***Session #9: Esteem and Making Amends*** The therapist reviews with the client the Challenging Beliefs worksheet on beliefs that hinder making amends and developing esteem for self, others, and God. The therapist also reviews the Making Amends and Verbal Blessing worksheets with the client. The session ends with a brief discussion about the concept of power/control (P/C) as it relates to self, others, and God, as well a brief introduction of the Spiritual Discrepancies concept as it relates to P/C.

***Session #10: Power, Control, and Spiritual Discrepancies*** The therapist further discusses with the client issues related to P/C and self-blame, and addresses Spiritual Discrepancies with regard to P/C. The therapist then begins to discuss intimacy issues related to self, others, and God, and introduces the concept of spiritual partnerships. For homework, the client is asked to read the Intimacy Module.

***Session #11: Intimacy and Spiritual Partnerships*** The therapist begins with a discussion of issues related to increasing intimacy/participation in a spiritual community. Next, the therapist introduces the topic of safety as it relates to self, others, and God. Finally, the therapist discusses the concept of post-traumatic growth with the client. For homework, the client is asked to write the final Impact Statement.

***Session #12: Safety and Post-Traumatic Growth*** The final session begins with the client reading the final Impact Statement. The therapist then reads the client's first Impact Statement and they compare the differences. The therapist then addresses any remaining stuck points related to moral injury, reviews the course of treatment and the client's progress, and helps the client to identify goals for the future. Emphasis is placed on "paying it forward" to others, family, spiritual community, and those in need.

Each session above is firmly grounded on scriptures in the Bible, particularly the New Testament, and so is overtly Christian. In summary, SICPT-C is a Christian-integrated form of psychotherapy that is specifically designed for Christian clients with moral injury in the setting of PTSD, particularly those who indicate their religious faith is important. Research is now being done in order to refine this treatment strategy, and hopefully, both therapist manuals and client workbooks will soon be available.

## Treatment Recommendations

Christian-integrated therapies are appropriate for clients who self-identify as a Christian and would like a Christian-integrated approach to treatment. Occasionally, a client will not self-identify as Christian (e.g., they identify as spiritual) but may explicitly request a Christian approach. In this case, a Christian-integrated therapy would also be appropriate, with the understanding that regardless of how the client self-identifies or the approach they request, the approach can always be modified or discontinued should the client change their mind in the future. This type of therapy is not indicated for clients who do not identify as a Christian and/or who do not want a Christian-integrated treatment approach. These therapies have the most empirical support for treating depression and anxiety, and some support for treating moral injury in the setting of PTSD. As such, therapists can feel the most confident using these therapies to treat these conditions. More research is needed using these treatment approaches for other types of mental health issues.

It is important to note that it is the client's Christian belief system that is drawn upon in Christian-integrated therapy, not the therapist's religious (or nonreligious) belief system. Thus, the therapist need not be a Christian. Furthermore, the goal of Christian-integrated approaches is not to engage in theological debates or discussions, proselytize, or take the place of religious professionals or clergy. Rather, therapists help clients to use their religious beliefs and practices as resources for recovery and well-being. They also help clients to explore potential spiritual struggles and how these might be contributing to mental health issues, such as depression or moral injury. Clergy can be important and helpful sources of collaboration, consultation, and referral during Christian-integrated therapy when issues arise that are beyond the scope of the psychotherapist. Issues that are beyond the scope of therapy include answering theological questions, providing spiritual direction, and administering spiritual rites, such as communion or absolution, and in many cases prayer.

Given the longer session times, frequency of treatment, type of training, and licensing requirements, psychotherapists are in the best position to administer the types of Christian-integrated therapies discussed in this chapter. That said, psychiatrists can still play an important collaborative role with a client who desires a Christian-integrated approach. While the therapist may be the one administering the therapy, psychiatrists can provide verbal support for this approach, follow up with clients about their progress, and inquire with the client (and therapist) how they can best support the therapy goals. Nevertheless, many psychiatrists may wish to take the time to conduct psychotherapy with patients and integrate the client's religious beliefs into the therapy, which is absolutely appropriate. Clients often want to speak to their healthcare providers (including psychiatrists) about religion and spirituality, but many believe it is the provider's responsibility to bring up the topic first [21]. Thus, a psychiatrist who asks their clients about the role of faith in their lives (i.e., take a spiritual history) can open up this important dialogue. They can also then play a role in making a referral to a therapist who integrates Christianity into their treatment approach (or do it themselves).

Training is probably necessary for a non-Christian to integrate a Christian's religious beliefs into psychotherapy. As noted earlier, we have a manual for administering Christian CBT, which the non-Christian therapist could follow. However, supervision by a Christian provider experienced in this form of therapy would certainly be helpful. Likewise, referring patients who want their Christian beliefs integrated into therapy to someone trained to do so would be a quite acceptable option. Most Christian patients, however, will not be requesting that their beliefs be integrated into their therapy but rather will simply want them to be respected and supported. Just listening without providing any advice often helps patients work out their spiritual struggles by themselves, so that a non-Christian mental health provider need not be an expert on those beliefs.

## Cautions

Regardless of where in the world mental healthcare professionals are practicing, it is important to tread lightly when seeking to integrate the Christian beliefs of Christian patients into therapy, always asking for permission from patients to do so (sometimes even written permission, particularly when practicing in a secular healthcare system). Treatment must be provided in such a way that allows the patient to guide the therapist on how and to what extent they wish their religious beliefs to be integrated into the treatment. In other words, treatment must always be patient-centered. It is about the patient's religious beliefs, not about the therapist's beliefs. Christian beliefs vary widely throughout the world, requiring that the mental healthcare provider carefully identify what those beliefs are when taking the initial spiritual history prior to beginning treatment. Treatment should then be provided a way that shows respect and honor for those beliefs, especially when the patient's beliefs differ from those of the therapist.

Christian providers must be careful to remain as neutral as possible when providing religiously integrated care, being cautious not to unduly influence the patient's belief system given the power dynamics involved and the vulnerability of the mentally fragile patient. Failure to do so may result in severe consequences, such as the reporting to authorities by patients (or family members) that they were unduly influenced, increasing the likelihood of litigation. Nevertheless, fear of litigation or unduly influencing the patient's Christian beliefs should not stop providers from integrating those beliefs into therapy, but should prompt them to constantly bear this concern in mind. Given the personal and sensitive nature of religious beliefs, as noted earlier, it is essential at all times to respect and honor the beliefs of the patient, even when they appear to be pathological, seeking collateral information from family members and assistance from the patient's clergy when such concerns are present (after explicit permission has been obtained from the patient).

## Summary and Conclusions

In this chapter, we focused on the topic of Christian-integrated psychotherapy. First, a background was provided that examined observational and experimental research on the relationship between religiosity and mental health in Christian-majority populations. This included a summary of the research on Christianity, coping with stress, its relationship to negative emotions (depression, suicide, anxiety, psychosis, alcohol use/abuse, and drug use/abuse), and its relationship to positive emotions (well-being, hope/optimism, meaning/purpose, self-esteem) and social interactions (giving and receiving social support). We briefly summarized the research on religious/spiritually integrated therapies more broadly, including both Christian and non-Christian interventions, which form the evidence base for this treatment

approach. We then focused on research examining Christian-integrated psychotherapies and provided examples of research studies in this regard.

Next, Christian religiously-integrated cognitive behavioral therapy (CRCBT) was described, indications for this form of treatment are provided, and a brief summary of each of the ten sessions was provided. This was followed by a discussion of spiritually integrated Christian cognitive processing therapy (SICPT-C) and indications for this approach, and a brief summary was provided of the 12 treatment sessions that make up this new intervention for MI in the setting of PTSD (which is currently being refined and tested). Finally, we make treatment recommendations for identifying clients in whom Christian-integrated therapies are indicated (and not indicated), determining when referral is necessary, and doing co-therapy with a psychiatrist when medication is indicated.

Christian-integrated psychotherapy is an effective treatment for depression and anxiety disorders, and there is preliminary evidence that it may also be effective in the treatment of moral injury in the setting of severe trauma. Integrating patients' Christian beliefs into therapy should always be done cautiously and sensitively, avoiding undue influence. Such concerns should not prevent therapists from doing so, after obtaining permission and following the guidelines suggested above.

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# Chapter 14
# Models of Delivering Christian Psychiatric Care


**Tom Okamoto, Mena Mirhom, Karen Wang, and Wai Lun Alan Fung**

## Introduction

Christian psychiatric care dates from Christ's historical ministry on earth, including healings of both physical and mental illnesses [1]. His healing actions were personalized, creative, intimately relational, and ultimately spiritual, producing life-changing restoration of health.

It is often thought that faith and science in psychiatry have only recently made attempts to partner with mutuality of purpose [2]. However, since psychiatry became a medical specialty, Christian practitioners have tried to incorporate both spiritual and scientific truth within their respective times and cultures. Christopher Reil, the son of a Lutheran pastor and highly regarded German physician who named the

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field of "psychiatry," called for the integration of psyche, soma, soul, and medicine as a guide for the psychiatric field [3]. This integration of the spiritual and scientific continues to challenge Christian psychiatrists caring for the mentally ill, compelling the ongoing creation of new ways to heal within evolving cultural standards.

This chapter presents Christian psychiatric service delivery models from the past through the present, as they negotiate the tension between faith and science, balancing state-of-the-art psychiatric health care with delivery of a spiritually congruent healing experience.

## Historical Care (Tom Okamoto)

Long before the time of Hippocrates, mental illnesses were recognized and studied. Healers around the world in spiritual and scientific disciplines have since debated the origins, meanings, and treatments for mental illness, converging and diverging in their purpose and understanding [4].

Some Christians throughout history have promoted exclusively spiritual explanations for mental illness, employing only spiritual resources for its care. Others have promoted only science-based medical approaches, and still others promote the integration of both views: Nevertheless, as Thielman [5] notes, "major religious traditions throughout the world and throughout history have been at the forefront in providing humane care to the mentally ill or emotionally vulnerable. Many of the most important breakthroughs in compassionate treatment of the mentally ill were made by persons of faith crusading for those who did not have the power to speak for themselves." Even before the discipline of psychiatry existed, during the Middle Ages, "sin became viewed less and less as the cause of mental illness" [6]. With the onset of the Age of Reason and the Enlightenment came scientific nonreligious explanations of mental illnesses. But since no proven treatments were available, asylum reform became the focus [7]. More humane, "moral treatment" was driven in part by a Quaker church leader, William Tuke, and the Society of Friends (Quaker church). Tuke was not a physician but was moved to redevelop a psychiatric asylum, the York Retreat, in 1796 after a fellow Quaker died while in the squalid conditions, typical for psychiatric care at the time. This first psychiatric hospital to promote moral therapy included the use of religious precepts and emphasized humane treatment of the mentally ill [8]. "The father of psychiatry" in France, Philippe Pinel, also a religious man, produced asylum reform around the same time, independently creating a medically based "moral therapy." He distanced himself from the more religiously based treatments, prohibiting antitherapeutic religious elements in his therapies [9].

In the United States, Friends Asylum was founded in 1813 by the Society of Friends. It was the first American faith-based psychiatric hospital. Thomas Kirkbride, a Quaker physician, trained at this hospital, became a founder of the precursor to the American Psychiatric Association and is considered one of the "fathers of American Psychiatry" [10], along with Benjamin Rush, who was also a devout Christian. Rush was another major figure developing psychiatric care in the

United States based on "moral therapy," integrating faith and scientific psychiatric treatment at that time [11].

In the twentieth century, psychoanalysis became a prominent scientific force in psychiatry. Freud devalued religion as a neurosis and minimized belief in God [12], despite efforts by his friend, Oskar Pfister, a Swiss Lutheran pastor, who argued that psychoanalytic concepts and belief in Christ were compatible, not mutually exclusive. Pfister, known then as the "analyst-pastor," promoted Christ as the "first psychoanalyst" and wrote an authoritative text on psychoanalysis [13].

The Freudian negative view of belief in God was also challenged by members of the British Middle School of psychoanalysis, including object relations theorists Fairbairn, Guntrip, and Winnicott, who promoted religious experience as a natural part of development [14]. Oskar Pfister and Winnicott also supported the scientific psychiatric view that religion is a positive influence in mental health [15, 16].

In the mid-1950s through the 1980s, psychopharmacologic discoveries of lithium, chlorpromazine, imipramine, and fluoxetine (Prozac) became treatment miracles, revealing psychiatry as scientifically credible, demonstrating mental illnesses as treatable, and its symptoms of pain and suffering relieved or at least improved through the use of these medicines [17].

Continued advances in brain sciences encouraged the realignment of neurophysiologic function and religious belief. A recent review summarized key functional magnetic resonance imaging studies correlating the neural physiology of religious belief and of other cultural influences [18].

## Current Models

We describe below two outpatient models and one inpatient model, each fashioned to serve demographically unique Christian populations. These programs are meant to show both creative, positive elements and obstacles to developing a viable current, socially relevant program of Christian psychiatric care.

These programs incorporate a spirituality shared by the faith communities which validated and have made referrals to them, as they engaged business and clinical challenges. Their deliberately integrated approaches aim to provide a spiritually rich environment for the patient whose faith is at the core of their identity and who otherwise would not easily engage a secular psychotherapeutic or medical treatment regimen.

## St. Luke's Health Center (Mena Mirhom)

St. Luke's Health Center is a nonprofit clinic that has been providing free, high-quality psychiatric care since 2012. Based in New Jersey, United States, it is hosted and staffed by members of the Coptic Orthodox Church. The term "Coptic" is

derived from an ancient term meaning Egyptian, and the Church's tenets were outlined in the Nicene Creed. It is currently the largest Christian community in the Middle East, with monasteries, schools, and parishes in every major city in the United States and Canada.

**The Community** In the Orthodox Church, sacred practices, called *mysteries* or *sacraments*, are means by which the grace of God is brought to the parishioner through a tangible act. Examples include the Eucharist, marriage, and the unction of the sick. The sacrament of *repentance and confession* is practiced by all members. This involves private discussions that are similar to therapy. The priest and the parishioner maintain contact throughout the years as the priest transfers the absolution of Christ to the parishioner. Confidentiality helps to build trust, so that parishioners divulge vulnerabilities, such as mental health struggles which can be addressed with spiritual interventions.

In the tight-knit Coptic Orthodox Christian community, physicians are also trusted sources of information. A physician in any given parish would be accustomed to members of the parish approaching them with "curb side" medical questions, usually regarding routine medical care.

**Clinic Origins** A local psychiatrist began to receive a growing number of questions from both parishioners and priests. These were mental health concerns that impacted individuals, families, marriages, and parishes overall, and came from all ages, genders, and socioeconomic classes. The psychiatrist would work with the family and clergy to refer the individuals to professional care. As the psychiatrist was later asked to join the clergy himself, he realized these cases were only the tip of the community's "untreated mental health iceberg." Dozens of patients were coming to him daily from around the country asking for "confession." They were told that a priest, who was also a practicing psychiatrist, would help with their unique concerns. Indeed, clergy are often the first point of contact for Christians experiencing mental health problems.

The doctor/father desired to care more specifically for the souls of his patients (hence his priestly vocation). As a psychiatrist, he was keenly aware that the mental illnesses he was treating would significantly impact his parishioners, their relationships with God, and the church community. He was determined to find a solution as he had the experience and vision, but little time. So, he and I (Mena Mirhom, M.D.) began working together to establish the clinic. We recruited a team for operations, including an attorney and administrator. We investigated potential free locations, an electronic medical record system, and other medical legal setup. The father worked to recruit two other volunteer psychiatrists, a psychologist, and social worker providers and oversaw their clinical work.

**Referrals** Awareness of the service has been primarily raised through word of mouth, and new patient phone calls come largely unsolicited. Through time and training, the priests have become a prominent referral source. Through the sacred relationship surrounding confession, they guide the struggling parishioner to consider treatment. While they refrain from giving diagnostic opinions or treatment recommendations, they support and "bless" their decision to seek care. This enables

the patient to feel that this is not a sinful attempt to remedy a deficiency but rather a sacred path of healing, ultimately blessed by God.

**Challenges** The Orthodox Christian community encountered numerous barriers to providing mental health treatment. Financial, cultural, and religious barriers were among surmountable hurdles.

***Financial*** In New Jersey where the clinic is located, a significant number of psychiatric providers practice outside of insurance networks. For the average middle-class family, paying for psychiatric care out of pocket is not possible. This is true for many Americans, including immigrants and refugees. This free community clinic costs nothing out of pocket. For patients who have no insurance and are struggling financially, this is a lifeline.

***Cultural Stigma*** In Middle Eastern culture, serious mental illness and common mental illness may be mistakenly connected. Therefore when a person states they are receiving care for "mental health," it may be unclear if this is for depression or schizophrenia. This can further stigmatize the process of seeking care. This misunderstanding comes, in part, from popular cultural portrayals in films, books, or other forms of media that depict mental illness as nearly terminal and treatment resistant. Psychiatric hospitals are often depicted as archaic, barbaric, and dangerous. In recent years, the narrative in popular culture has begun to shift and to normalize young people seeking therapy. In order to combat low mental health literacy and reduce stigma, several anti-stigma initiatives have been pioneered by the Orthodox Christian Association of Medicine, Psychology and Religion (OCAMPR) as well as by the Coptic Medical Association of North America (CMANA).The culture of blame is illustrated in a biblical passage where disciples of Jesus asked him whose sin was to blame for a man's blindness. Jesus clarified that sin was not responsible for this man's blindness, but his healing demonstrated the glory of God (John 9).

In a society that highly values the role of family, its members often believe they have caused the mental illness that is destroying the life of the suffering individual. Privacy can be problematic as the family expects involvement in treatment [19]. While family involvement can be beneficial, it can also be countertherapeutic for the patient [20].

This lack of understanding of mental illness may cause a family to hide the struggling individual instead of seeking help. This is partly due to ignorance of help that is available, which is further compounded by community stigma and self-stigma. Discrimination against the mentally ill occurs in schools, work settings, attaining marriage, and other social activities. The stigma of mental illness adds to the injury already present.

Because of stigma, somatization of mental health symptoms is common [20]. It is more acceptable to report shoulder, stomach, or back pain to the doctor than to report depression. Somatic symptoms are more likely to be taken seriously than depression [21].

***Religious Stigma*** The Orthodox Church has a long history of describing features of mental health concerns and addressing them through spiritual remedies. Desert Fathers have described the "noon day demon" who attacks and leads the monk to despair even of life itself. The Orthodox understanding of how thoughts impact mood is described extensively by the early church fathers.

At times, this ancient wisdom is misused, replacing rather than supplementing mental health care. While the church recognizes the model of biological, psychological, social, and spiritual care, the false dichotomy between faith and medicine is accepted by many, despite its theological error.

Serious mental illness brings confusion over the role of the demonic. When disturbing symptoms of psychosis such as delusions or hallucinations are exhibited by a patient, a family may at times wonder if demonic possession is responsible, and may seek spiritual intervention before psychiatric care.

Educational campaigns in the church are supported by clergy at every level, clarifying misunderstandings and conflicts with parishioners. This is discussed in more detail in another chapter of this book [22].

For some patients, mental illness is seen as a defect of spiritual character. How can a practicing Christian despair when God is the source of joy, or a Christian suffer constant anxiety when God is the prince of peace?

While faith is a source of support, strength, and well-being, it can also reinforce shame and guilt. If "good Christians" should not experience despair, then one who is depressed cannot be that "good Christian."

These conflicts can prevent care. Parishioners may deny that mental illness exists, feeling that these symptoms conflict with their "Christian identity." If the individual can lift that barrier and acknowledge that a Christian can indeed feel depressed, the next challenge is engaging treatment. Shouldn't therapy be provided within the faith context? Would medication replace God's role in healing? Therapy and medication are often falsely contrasted with, instead of complementing, faith.

Addressing the most difficult barrier, religious stigma, has been a critical task of the clinic over the years. Patients fear experiencing traumatic shame, blame, and stigmatization. The very presence of the clinic provides the patient "permission" to be ill and seek treatment without judgment. If a religious authority can prescribe medication, a formidable barrier erodes. The physician as priest in confidentiality establishes trust with the patient. The oath of confession carries over to the exam room of the psychiatric office. This validates the patient as no less than other parishioners. Their faith is not inferior, and their Christianity is not in question as their treatment is *sacred* rather than *sinful.*

## *Limitations*

As free quality mental health care is a limited resource, it is critical to allocate it to those who need it most. Patients who are referred to the clinic are screened by the medical director.

For many patients, the desired outcome is for the "blessing" to seek mental health care elsewhere. Once they are provided the psychoeducation to know their Christianity, character, or personhood will not be diminished, they can comfortably pursue care through their insurance panel. Not every patient who calls will be seen in the clinic. There are patients who experience temporary financial hardship, and through psychiatric stabilization regain employment and can be referred.

## *Benefits*

Some patients are comfortable speaking with a Christian provider within their community but are not comfortable speaking with a priest. For these patients, these clinic psychiatrists are a valuable resource.

The clinic has cared for parishioners with a wide range of ages, socioeconomic status, and severity of illness. Patients with mood disorders, psychotic disorders, substance use disorders, and other conditions have been treated. Parishioners struggling for years with illness finally receive treatment, reengage the community, and reclaim their lives. We have been surprised and encouraged by these routine miracles of positive impact on patients' lives.

In the biological-psychological-social-spiritual model of care, the clinic becomes the link that helps patients integrate critical dimensions of their lives. We help the patient see that there is harmony here. As the scripture says, "Every good and perfect gift is from above, and comes down from the Father of lights" (James 1). The patient can see that those gifts include the spiritual and social support they currently enjoy, as well as the newly found biological and psychological support in St. Luke's.

### Considerations in Starting a Church Clinic

1. Location

When considering clinic location, a waiting room enhances privacy. Our clinic rents a portion of a facility for limited hours per week, reducing costs and allowing the clinic to grow slowly.

In the COVID-19 era, the opportunity to have the clinic operate remotely is important. This can increase patient access to the clinic, and can increase access to other volunteer subspecialists.

2. Technology

Remote service requires several technology considerations including the video platform used by clinicians to meet with patients. HIPPA compliance and BAA agreements are essential.

The electronic medical record is another essential consideration. Several options offer discounts to nonprofit organizations.

3. Staffing

   Essential staff include clinicians (therapist, psychiatrist) and administrative staff.

4. Liability

   Legal assistance is necessary to ensure compliance.
   Liability coverage for each clinician and the facility is a critical component.

5. Triage screening

   Demand for such a clinic will vary over time, and a process must be implemented to screen and triage potential patients, developed with the treatment team.

## Tyndale Psychiatry Clinic (Karen Wang and Alan Fung)

Tyndale University is a Christian university situated in the center of Toronto, Ontario. With a population of over 2.9 million, its mental health needs are unique as it is home to immigrant families, international students, refugees, and non-English speakers. Tyndale University was established 125 years ago. Initially the Toronto Bible Training School, a theological institution for clergy training, it has expanded to become a full-scale private Christian university, awarding both undergraduate and graduate degrees.

One of Tyndale University's largest and most robust programs is the Master of Divinity Counselling that prepares candidates for a career in clinical counselling and church ministry settings. The training focuses on theological and psychological understanding of human personhood and therapeutics in areas including Christian counselling, marriage and family therapy, child and adolescent counselling, pastoral counselling, and crisis intervention. The Tyndale Counselling Service (TCS) prepares these trainees with registered and qualifying psychotherapists providing psychotherapeutic support to staff and students.

Tyndale University offers every student 10 free counselling sessions each academic year, totalling 5000 therapy sessions per year. Furthermore, the public facing arm of the Tyndale Counselling Service, the Family Life Centre was established in 2016 to meet the mental health needs of the Toronto community. Amid this busy counselling service and the Family Life Centre, there developed an obvious need for psychiatric services to provide diagnostic clarification, medication initiation, and subspecialized referrals. There was a desire for Christian psychiatrists to provide a holistic approach to psychiatric care and consider the intersection of faith and mental health. Most students, staff, and faculty referred have an evangelical background, and despite advances in destigmatizing mental health care, attitudinal barriers exist. It was felt that Christian psychiatrists would help students, staff, and clients seek appropriate care while understanding their worldview.

In 2016, co-author WLAF started providing psychiatric consultations to some Tyndale students. In 2017, with the support of Tyndale leadership, a more formal

psychiatric service was established when co-author KW pursued a clinical elective at Tyndale during her PGY5 psychiatry residency training, supervised by WLAF and Rev. Sheila Stevens, Director of the Tyndale Counselling Service. Subsequently, KW joined WLAF as a consultant psychiatrist for the Tyndale Counselling Service, providing consultations to students, staff, and faculty in addition to Family Life Centre clientele. The psychiatrists were highlighted as integral members of the TCS and met regularly with the Director of the TCS. Emphasis was placed on building a collaborative, stepped care model that involved more than simple co-location of services but rather a partnership with fluid information exchange, teaching, research, and continuity of care. The joint venture was also a means of bridging the schism of previous decades between mental health (which had swung to a neuroscientific approach) and Christian counselling.

**Structure of the Model** Tyndale Psychiatry utilizes a stepped care model whereby therapists seeing clients for a predetermined period (8–10 sessions) may refer them for a psychiatric consultation when there is lack of treatment progress, questions about psychiatric diagnosis, or recommendations for medication initiation/management. Most consultation referrals are related to common mental health concerns such as anxiety, depression, personality disorders, parent-child relationship conflict, and academic struggles. Tyndale therapists are given an orientation to the psychiatric service each academic year, clarifying psychiatry's role in the counselling service as well as introducing new therapists to the psychiatric staff. It is emphasized that psychiatric care is not meant to replace the counselling service nor should the consultation be offered to manage nonurgent mental health needs. Given that nearly one in five Canadians have a mental illness, psychiatric services are in high demand, and there are relatively few practitioners who can adequately treat patients. Establishing appropriate referral parameters protects this vital and limited clinical resource.

Tyndale Psychiatry provides services to those who cannot be adequately treated with therapy alone. Therapists and their clients identify the main reason for seeking a psychiatric opinion prior to setting an appointment. Rigorous vetting and triaging referrals ensure appropriateness. Any referrals that cannot be accommodated are returned to the primary provider with a detailed explanation and alternatives for outside psychiatric services. Once a referral has been accepted and an appointment set, therapists are further encouraged to attend the consultation with their client, providing a unique training opportunity. Clients are then followed briefly by the consultant psychiatrist, typically for 3–6 months maximum. Urgent consultations are typically completed within a 3–4-week time frame, and a detailed note is returned to the therapist in addition to the primary provider with recommendations.

Therapists are encouraged to follow up with the psychiatrist if there are further concerns with case conferences scheduled as needed. Measurements of both anxiety and depression by standardized, validated symptom rating scales are used routinely in both the psychiatric consultation and ongoing therapist visits in order to document progress and track signs of early clinical deterioration. An administrator

handles all incoming referrals, ensuring that documentation is managed appropriately and that consultation notes are processed in a timely fashion. In the past year, as the number of referrals has continued to grow, three additional Christian psychiatrists have been recruited to form an extended consultation base.

**Opportunities and Challenges** Integrating psychiatric perspectives within a Christian counselling center presents unique opportunities and challenges. A unique opportunity working within a university context was the collaboration of the Tyndale Counselling program with other professional programs (e.g., Bachelor of Education) to provide training around mental health issues. A consulting psychiatrist was asked to provide child and adolescent mental health training because of her subspecialty background. Through the lecture series for both counselling students and teacher candidates, over 12 additional mental health seminars were given over a 3-year period.

Bringing on new physicians for a new clinical service posed major organizational and administrative difficulties. One of the biggest challenges was to ensure a truly integrated mental health model rather than a clinical service existing in a silo. To overcome this challenge, detailed discussions were held with the Director of the Counselling Services and Tyndale senior leadership to review the model of care, ensuring the academic community at large was fully supportive of this creative endeavor. Presentations were made to the academic faculty in anticipation of the clinic opening in addition to new marketing strategies (e.g., change in website design, advertising biographies of clinicians online, clear signage).

Students form the core referral population. Numerous ADHD assessments and need for academic accommodations were challenging. Psychiatric referrals surged leading up to the fall and throughout the end of term examination time. Students often seek a physician's accommodations for their learning struggles much too late, as when they were borderline failing a course. The solution was to encourage therapists to send in referrals early for their student clients to ensure they could obtain their accommodations earlier to lessen the risk of losing course credits.

Another potential challenge providing psychiatric care within an academic setting is managing severe cases with possible imminent risk of harm to self or to others. There are instances where a seriously ill student or patient needs to be certified under the Mental Health Act. Due to the possible need for higher-level care, the consultant psychiatrist also has hospital admitting privileges for nearby inpatient care. As the hospital medical director approves the incoming admission, the Tyndale client can avoid a lengthy emergency department visit, entering the inpatient unit directly. The consultant psychiatrist can provide direct transfer information to the admitting team, and the client can obtain treatment in a timely and efficient manner. The Tyndale therapist and Director of Tyndale Counselling Services can facilitate suspension of coursework, exams, and academic leave from school until full recovery can be made.

**Principles for a Mental Health Clinic in an Academic University Setting** There are unique complexities to consider when establishing a mental health clinic within

a university setting. The following points highlight issues that must be addressed proactively to run a full clinical service:

1. Conducting a needs assessment – Establish the type of patient population that is best served by the proposed model and seek to understand the mental health challenges and concerns faced:
   (a) Obtain data on the number of clients that would typically be referred and types of cases that would be seen by psychiatric consultant.
   (b) Ensure that psychiatric consultant has expertise in areas that would be most prevalent within this university setting.
   (c) Identify which type of model would best suit the patient population (e.g., consultative model; brief follow-up; longer-term follow-up care and management)
   (d) Identify any security issues as students may have consultations at night or on weekends.
2. Working with university leadership to establish a clear organizational hierarchy for clinic operations:
   (a) Establish employment agreements and hiring of suitable administrators for managing the clinic.
   (b) Discuss financial obligations on both sides (e.g., who will pay for the administrator and clinic materials that are needed).
   (c) Clarify expectations around reporting duties including how often reviews of the clinic will occur with university leadership.
3. Identifying any resource challenges and barriers that may arise in managing the identified patient population:
   (a) Will this population require intensive case management?
   (b) How will they be referred?
   (c) How will patients have appropriate follow-up?
   (d) Are there sufficient therapeutic resources in the community to support ongoing referrals?
   (e) How will severely medically unwell patients will be handled and where they may be transferred in the event of a psychiatric emergency?
4. Managing the legal and technological resource issues:
   (a) Identify the appropriate way to document clinical encounters and manage intake and triage of patients.
   (b) Consider utilizing a mental health progress note template to simplify documentation.
   (c) Consider using a centralized digital platform housing all medical records and documents.
   (d) Consult with local medical legal resources to ensure compliance with health information privacy act, documentation concerns, and other legal responsibilities as health-care providers.

5. Establishing a clear communication plan between the psychiatry staff and the academic institution:
   (a) Refer students with learning challenges who may require additional communication and advocacy work on their behalf.
   (b) Ensure appropriate linkage to accommodation office if the student requires learning support/accommodations.
   (c) Consider offering faculty workshops/seminars to identify mental health issues in students.
6. Maintaining a quality improvement framework to ensure gaps in care are filled appropriately:
   (a) Ongoing improvements in clinic management are made using an iterative framework (e.g., Institute for Healthcare Improvement Model of Improvement).
   (b) Set regular meetings with counselling team leadership and administration to review psychiatric service mandate and outcomes.
   (c) Track measurements of patient symptoms using validated rating scales to monitor progress.

**Future Directions** In the next 5–10 years, more Christian psychiatrists will be recruited into the Tyndale Psychiatry clinic as referrals continue to rise. There is heightened demand for services amid the global pandemic. Psychiatrists within the academic institution can train future Christian counsellors. As Tyndale University has educational agreements with other academic institutions in Ontario, expansion to training psychiatry residents including practicum/residency rotations supporting an integrated care model is possible. Additional public education opportunities including media interviews have been requested from the consulting psychiatrists working in this setting.

## Minirth-Meier Clinics West Program (Tom Okamoto)

This program was based on an inpatient model originally run by Frank Minirth, M.D., and Paul Meier, M.D., in Richardson, Texas. These two psychiatrists approached two psychologists, John Townsend, Th.M, Ph.D., and Henry Cloud, Ph.D., to develop a West Coast program, and with a psychiatric medical director, Tom Okamoto, M.D., set up a multisite inpatient, day treatment, intensive outpatient adult, and adolescent psychiatric acute care model in different locations on the west coast. They operated in the 1990s and 2000s. Referrals were received through a network of outpatient practitioners, both psychotherapists and psychiatrists, as well as an informal network of evangelical Christian Protestant churches. These networks and referrals were assisted through a popular daily radio program which was heard on Christian radio stations up and down the west coast, using a call-in format addressing counselling, church integration, and psychiatric public education issues. Their referral network was also supported by local Southern California

weekly public psycho-spiritual education meetings, including topical spiritual and mental health integration issues with a question-and-answer component.

**Inpatient Treatment**
The Minirth-Meier Clinics West of Newport Beach, California, were voluntary psychiatric inpatient and outpatient units operating in different hospitals. They promoted a Christian mental health content within their psychological treatment model but did not exclude nonspiritual patients or nonbelievers if they were aware of and comfortable with the Christian focus. The ages of patients ranged from adolescents to geriatric. The patient demographic was generally middle to upper middle class and funded through medical insurance benefits or private funding.

The treatment program has been described elsewhere in detail [14]. It included the following:

- Psychotropic medications (as needed) administered by a staff psychiatrist.
- 30 min of individual psychotherapy with a primary therapist 5 days per week.
- 90 min of group psychotherapy per day, 7 days per week.
- A 1-hour didactic session, 7 days per week, teaching aspects of psychological/mental/spiritual health and recovery based on psychological and biblical principles.
- Milieu treatment, including community meetings, occupational therapy, psychodrama, and vocational counselling as needed.
- A weekly worship service made available by pastoral/clergy, and the treatment program was based on the Cloud-Townsend model [23, 24].
- Weekly staff meetings on all patients performed using a team approach, including psychiatrist, program director-psychologists, individual psychotherapists, nurses, OT, and group psychotherapists participating.

The psychological orientation of the Cloud-Townsend model, which was used at Minirth-Meier Clinics West, was predominantly ego psychology/object relations [25].

**Day Treatment or Intensive Outpatient Programs** The clinical treatment models of the day programs (5–6 days per week) or intensive outpatient models (3–5 part-days per week) were structured similarly to the inpatient model, with identical content of didactic education, psychotherapeutic programs, and philosophy of treatment models, as well as the inclusion of psychiatric care. Frequency of individual and group therapies and ancillary groups and milieu therapies were scaled according to the frequency of attendance. Follow-up treatment consisted of 2 weeks of aftercare as a transition between hospitalization and discharge, free of charge. Outpatient psychotherapy was recommended, including 12-step or other groups, and referrals to therapists and psychiatric care were given according to the patient's needs.

## Opportunities and Challenges

*Unique Opportunities*
- Removing stigma

- Serving those who previously did not have spiritual "permission" to submit to care
- Educating about manifestations of psychiatric disorders as treatable symptoms of illness and not a sign of spiritual or character weakness
- Correcting unhealthy and maladaptive religious beliefs and practices toward emotionally healthy spirituality
- Providing education and research to further develop better systems of mental health-care delivery

*Unique Challenges*
- Fitting needs for treatment to financially available clinically appropriate options
- Providing the highest level of clinical care within a (US) medical care delivery system that is complex, expensive, and highly regulated
- Maintaining professional psychiatric and medical clinical, physical, and safety standards, with added spiritual resources while remaining financially viable and competitive
- Serving a Christian religious community that is heterogeneous, with a wide range of Christian beliefs and various denominational and theological differences
- Providing a psychiatrically and theologically effective and congruent Christian treatment paradigm as world cultures and societies shift through time

**Future Directions**
Our system of mental health-care delivery closed when the insurance industry disallowed payments to psychiatric units with "specialized" services, including eating disorder programs, dual diagnosis units, specialized mood disorder units, or Christian mental health units. There are currently inpatient Christian psychiatric units in the United States, serving both adolescent and adult populations, as there is a need for mental health care for this population, but these efforts will have ongoing challenges to maintaining excellence in care while providing integration of faith and mental health service.

## Implications for Practice (Tom Okamoto)

The programs described here illustrate recurring themes ranging from practical business challenges to defining the place of religion within psychiatry. Development of a faith-congruent program of care begins with a theologically integrated model of psychiatric care. Then local support needs to be enlisted, or at least the community should not be hostile to the program's operations. Support from pastors, priests, church leadership, and denominational is crucial. A church recovery and "reentry" support network is important for aftercare and reconnection of patients to the community while in recovery. Parachurch mental health support groups can also be enlisted for support and promotion of the program.

Business and legal consultations are valuable for competent service delivery, given the need for adherence to not only best medical and psychiatric practices but local and state professional and business practice guidelines. An economic model and business plan are crucial for the success of a service delivery model in a time when mental health care is underfunded and inaccessible for many.

Christian health-care delivery services can find complex social and cultural issues challenging. These include conflicts over spiritual and religious freedoms, abortion, gender identity, and racism. Given the relevance of these issues to a Christian view of healing, any Christian clinical practice should have developed policies or positions on the most challenging current social and theological issues.

## Summary and Conclusion

Eugene H. Peterson (1932–2018), a Presbyterian pastor, theologian, scholar, author, and poet, presented a Christian perspective on the difficulties working with both science and religion:

> As I edged into adulthood, I began meeting and reading the writings of Christian friends who loved science, some of them scientists themselves. Like so many of you in this congregation, they seemed to have no trouble integrating their Christian faith with the findings of science. I remember one friend telling me several months ago that science and religion are opposites, the way your thumb and forefinger are opposites: if you are going to get a grip on things, you need them both [26].

John Turbott, a New Zealand psychiatrist, referenced the psychoanalyst Margaret Mahler's concept of rapprochement. He stated "rapprochement, with religion should be sought if psychiatry wishes to be a complete, maximally effective and holistic healing method, and for the demonstrable benefit of patients" [27]. Mahler's concept of rapprochement, however, includes a process of restoring relationship through time, within an ongoing oscillation of mutuality and diverging identities.

In Dr. Mirhom's program, the parishioners in the Coptic Orthodox Christian Church inspired a psychiatrist-priest to develop a clinic model, with a unique and creative service, which allows for destigmatization of mental health care delivered through priest-referred services, redefining mental health care as a sacred function of spiritual life. Dr. Wang describes the creation and ongoing development of a psychiatric service within the Tyndale University, whose faith-based population and educational structure train Master of Divinity Students for Christian counselling, demanding spiritual congruence within a sophisticated modern care model.

The Minirth-Meier Clinics West Program was a unique example of an integrated spiritual, psychological, and psychiatric program that served the Christian church, demonstrating that science and faith can partner effectively to heal psyche and soul.

Psychiatric care and mental health service delivery systems will continue to require creative clinical and administrative health solutions as the Christian treatment of mental illness has been and will always be complex. Evolving societal and cultural changes will challenge the Christian faith, including the faith and practice

of Christian psychiatrists. These challenges require ongoing reassessment, improvement, and creative adaptation. The tension between science and faith will not find a resting place as Mahler's concept of rapprochement implies an ongoing work of creative tension between individual entities, creating a new relationship according to changing internal and external contexts. The Christian role model for healing includes personal intimacy and cultural relevance, and if psychiatry is to include psyche, soul, soma, and medicine accepting the tension between faith and science is necessary for both to progress as time and society changes. As in the past, the partnership and tension between faith and psychiatric science will continue. The commitment to find ways to serve those in need of healing will determine the unique nature of Christian psychiatric care in the future.

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# Chapter 15
# Clergy-Clinician Collaboration


**Nancy Clare Kehoe and Mary Lynn Dell**

## Introduction

"Clergy," "clinician," "collaborate," and mental illness each of these words merits brief elaboration as we examine this topic. "Clergy" refers to people recognized by a faith tradition as leaders and teachers within it. As Muslims refer to their faith leaders as Imams and Jews refer to their faith leaders as Rabbis, we will use the term "clergy" to refer to faith leaders of Christian communities. In the term "clinicians," we include not only psychiatrists but also psychologists, school counselors, psychiatric nurses, social workers, and related professionals. The dictionary definition of collaborate is "to work jointly with others." A review of the literature indicates that collaboration can take several forms, from temporary consulting to working together in an ongoing relationship. Reasons for different collaborative models will become clear as we consider shared provision of care for people in psychological, spiritual, or intertwined forms of distress. In using the term, "mental illness," we mean serious illnesses such as depression, bipolar disorder, schizoaffective disorder, schizophrenia, and post-traumatic stress disorder – illnesses that severely affect the way a person functions in the world and that frequently require medication and/or hospitalizations. While other disorders such as situational depression, panic disorder, and anxiety cause a great deal of suffering, it is primarily the more severe disorders that make collaboration critical.

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## Literature Review

The literature on collaboration between clergy and mental health professionals consistently reports that individuals with mental health problems who are involved in faith communities turn to clergy first for help during times of distress [1–8]. This is particularly so in Black churches [9–11]. Although most clergy have received some form of pastoral counseling training in their seminary work, many have not been adequately trained to deal with serious mental health issues [12–16]. None of the articles reviewed rejected the idea of collaboration; instead all supported the need for more. Three articles in particular cited times when collaboration was essential: with the growing incidence of suicide among the elderly [17], in dealing with trauma [18], and at times of natural and national disasters such as Hurricane Katrina in Louisiana and the Gulf South in 2005 [19] and the Upper Big Branch Mine disaster in West Virginia in 2010 [20].

Collaborations between clergy and mental health professionals take place within a historical context of suspicion, ignorance, and mistrust between these two groups of healers – making it challenging to achieve shared values, mutual respect, and accessibility. Clergy are not always seen as true partners in this work. For instance, clergy are more likely to refer a person to a mental health provider than vice versa [3, 4, 16, 21–27]. Family therapists work more closely with clergy than do clinicians in other disciplines [22]. Because of the dearth of mental health providers in rural areas [28], collaboration may be especially relevant in these areas.

Just as most clergy lack sufficient training to deal with serious mental illness, relatively few mental health professionals receive training in addressing patients' religious or spiritual needs. In a recent report of such a curriculum for psychiatric residents by McGovern et al. [29], most of those surveyed found it meaningful and helpful in their subsequent practice. But Hathaway [30] found in a survey of 333 members of the American Psychological Association (APA) that only 33% reported asking about religion/spirituality, and only 34% reported they had been trained to do so. A subsequent review by Schafer et al. [31] of training and education in religion/spirituality within APA accredited clinical psychology programs found an increase in supervision and courses, but no increase in systematic coverage. Furthermore, when religion/spirituality was incorporated into the curriculum, the primary focus was work with the mentally ill individual, with no references to the need for collaboration with clergy in the community. Similarly, a survey of 178 directors of School of Psychology Programs found that only 34 programs addressed the topic of religion/spirituality and only 35% of directors thought that it was important to incorporate in working with families [32]. Finally, only a few published guides exist for mental health professionals comparable to the American Psychiatric Association's *Mental Health: A Guide for Faith Leaders* [33, 34].

A limited literature describes the process of collaboration between mental health professionals and clergy. McMinn [23] distinguishes between basic and advanced competency, and suggests that when working with conservative clergy, the personal religious values of psychologists are likely to play a significant role. McRay [35]

makes a similar point regarding what evangelical pastors want to know about psychologists. A small but growing literature describes benefits to patients of mental health/clergy collaboration [25, 36, 37, 38, 39].

Finally, demographics are relevant to both the need and the opportunity for collaboration. The regions of the United States with higher levels of religiosity also report the highest prevalence of mental illness and the lowest access to care, while regions with lower levels of religiosity report significantly lower prevalence of mental illness with better access to care [40–43].

## Benefits

Mental illness often robs a person of a sense of self, hope, connection, meaning, and acceptance. Faith traditions offer belief in the value of each person, hope, a sense of meaning and purpose in life, and a community. While mental health providers treat symptoms and work to improve behaviors, faith communities help individuals find their place in a larger whole. Rather than being adversarial, the two disciplines can work together to complement each other, to the benefit of the client.

When mental health professionals understand the importance to the client of a religious commitment or spiritual practice, they discover a resource that can be incorporated into their treatment. Because they often do not understand different religious traditions, working with the clergy can be educational, and allay fears of clients that the healthcare provider does not understand their tradition and may misinterpret their beliefs and practices. Clinicians also may uncover a source of distress for the client in relation to certain religious or spiritual beliefs and work with clergy to understand the issues from the perspective of their tradition. At the same time, mental health professionals are educating clergy about mental illness.

## Challenges

The challenges to achieving collaboration are significant. Limited awareness of its value is a substantial impediment, but limited accessibility is also a major problem. As noted above, in areas of the country where the incidence of mental illness is high, the presence of mental health providers is low. Where the greater number of mental health providers reside, those connected with religious congregations are fewer.

Clergy often feel overwhelmed by the multiple tasks of pastoring a congregation, leading services, administering their properties, and sustaining the congregations financially. Providing counseling for individuals with serious mental illness requires a significant investment of time and training which clergy often do not possess. Collaborating with mental health professionals can preserve some of their time for other ministerial responsibilities. In developing working relationships between the

two disciplines, both can grow in an understanding and appreciation of what each brings to healing. The key is to develop a working relationship with mutual respect and knowledge of the availability of the other discipline in one's area of ministry and practice. Mental health providers should be aware of various religious congregations within a reasonable radius of clinical services, and clergy should know mental health providers and how to access them within the area they serve.

Another challenge is that some religious traditions have views of mental illness that do not lend themselves to reaching out to mental health providers.

Some faith traditions believe that the resolution for a "mental illness" can be found in prayer and in a greater effort to develop one's faith. Skepticism or outright rejection of the value of medication is promoted by some pastors. In giving a presentation, one of the authors (NK) was told by someone in the audience that his pastor told him to stop taking psychotropic medication; he did and required hospitalization. Sexuality is an area where clergy and mental health professionals frequently adopt different approaches. While mental health professionals aim to help a person understand and choose a personal direction, religious professionals often feel the need to serve as spokespersons for the specific teachings of their religious denominations on issues such as homosexuality, birth control, and abortion. Even within a particular religious denomination, clergy take different positions in regard to these dilemmas. Education, dialogue, and a genuine interest in trying to understand the mindset of another are all important.

Finally, collaboration builds on a network of relationships. Healthcare providers have connections with other professionals to whom they relate. Psychologists and social workers know psychiatrists to whom they refer patients for medication; both know psychologists to whom they refer patients for testing; most have lawyers to whom they refer. In this circle of networks, clergy are seldom considered essential members of the treatment team. Whenever one professional consults with another in a different discipline, confidentiality is required and the permission of the client/patient required. In *Ethical Considerations at the Intersection of Psychiatry and Religion* [11], Kehoe explores in more detail the complexity of the dual roles clergy often exercise, and the importance of having clear boundaries. Collaboration between clergy and mental health professionals, particularly in small communities such as are found in rural areas, requires particular attentiveness to confidentiality so that the client, a member of the congregation, is protected. Networks of relationships are key to successful clergy and mental health clinician collaborations, consultation, and referrals, based on profound respect for the person involved.

## Mental Illness Resources for Faith Communities

Education, familiarity, training, past perceptions, historical realities, fear, and mistrust all foster the silo mentality shared by clergy working in their arena and mental health providers working in theirs. However, when mental illness affects believers, connections can form between them, leading to the creation of new links to mental

health resources and educational opportunities. Perhaps the best known consumer mental health organization is the National Alliance on Mental Illness (NAMI), formed in 1979 when two women who had children with mental illness came together in Madison, WI, to combat the idea that mothers were responsible for their children's mental illness. Recognizing that no forum existed for mothers to talk about their experience of raising a child with mental illness, they helped NAMI develop more than 640 state chapters and affiliates [44].

Concerned that NAMI did not address the role of faith and faith communities in the care of the mentally ill, members of 15 faith communities and 2 mental health organizations created Pathways to Promise in 1988, to promote caring ministries for persons who had prolonged mental illness within congregations [45]. Its written resources, which include ministry manuals, bulletin inserts, and training curricula, are available in Protestant, Roman Catholic, or Jewish versions.

NAMI members who were also members of faith communities subsequently worked within NAMI to create NAMI FaithNet, which aims to raise the awareness of mental illness and treatment among clergy, congregations, and individuals who seek faith as a component of their recovery [46]. Other similar resources include the United Church of Christ Mental Health Network and Mental Health Ministries [47], whose purpose is to help "congregations become caring communities for persons living with a mental illness and those who care for them" [48]. While the websites of these organizations and the American Psychiatric Association's *Mental Health: A Guide for Faith Leaders* [33] are valuable sources of information, it remains unclear how much they foster actual collaboration among clergy and mental health professionals.

## Models of Collaboration

Cambridge, Massachusetts, is a small geographical area that is home to many different religious congregations, an organization of clergy and Cambridge Health Alliance (CHA), a teaching hospital network affiliated with Harvard Medical School. In 1977, as a psychologist and Roman Catholic nun, one of us (NK) who was on the staff at CHA realized that many of the patients who appeared in the emergency room on a Saturday evening were also seeking help from their clergy during the week. Because she attended the interdenominational clergy meetings that took place monthly, she learned of the challenges presented to the clergy by some members of their congregations who presented with serious mental health issues, suicidal ideation, and substance use disorders. In the mental health world at the time, an intellectual chasm existed between mental health providers and religion. Consequently, the mental health providers rarely inquired about a person's religious affiliation.

Relationships are key to any attempts to bridge diverse communities. Because one of us (NK) had relationships in both worlds, she could personally invite all who were interested to an initial gathering. The purpose was to recognize that both

communities were treating the same population of individuals but in ignorance of the other, and to explore interest in having an ongoing dialogue that focused on individuals with both faith and mental illness. About 12 men and women attended the first meeting, representing all the mental health disciplines and about 5 religious denominations. After reaching consensus on the purpose of the group, all agreed to meet monthly on Monday mornings for 90 min, and to reassess in 6 months. One month a religious professional would present a case from his/her congregation that had some mental health issues and receive feedback from the mental health professionals. The following month, one of the mental health professionals would present a case in which there were concerns related to a person's religion. As members of the group dealt with challenges to collaboration noted above with mutual respect, they began to trust and support each other. As they came to understand what each professional contributed to healing, they began to make referrals across disciplines. Members, some of whom came and went with job changes, evaluated the group on a yearly basis, and continued for about 8 years. This model of working together for the good of the patient could be replicated, even in rural areas, if clergy reached out to local mental health professionals, perhaps beginning with those in their own congregations.

One of us (MLD), a psychiatrist and Episcopal priest, has collaborated with clergy and religious professionals in several arenas over the past 30 years. The type and degree of mutual engagement has depended upon the amount and quality of medical and psychiatric services available in the community, the proximity to seminaries and pastoral care/chaplaincy training opportunities, and the vicissitudes of reimbursement for both outpatient mental health and pastoral care services over the past three decades. All of the following strategies bore the fruit of helpful collaboration across disciplines, both at the individual client or parishioner level and the larger systems levels, albeit over variable time periods. Consistently, the most helpful factors in productive cross-disciplinary partnerships have been the development of mutually enjoyable personal relationships between mental health and religious/spiritual professionals; mutual respect for each other's education, training, and experience; accountability at the larger organizational level (e.g., state medical boards, hospital employers, congregations, denominational structures, and authorities); and regular, open communication about the joys and challenges of each other's work and vocation.

Here are six practical examples of religious and mental health professional collaboration that are typically very actionable in most community settings, especially when grounded in a one-on-one relationship between clergy person and clinician.

1. *Medication management and pastoral psychotherapy*. For psychiatrists and other clinicians who prescribe, such as psychiatric nurse practitioners, this is an obvious and mutually beneficial relationship. Most psychiatrists, whether seeing clients in academia, private practice, community mental health centers, or other settings, spend the vast majority of their encounter time in psychiatric assessment and medication management. Many psychiatrists have not had extensive psychotherapy training and wish to focus primarily or exclusively on

psychopharmacological treatment, while others who do enjoy providing psychotherapy with medication management find their efforts to provide combined therapies stymied by limited time and/or restrictions of third-party payers. At the same time, pastoral counselors and psychotherapists have found themselves dealing with more clients with greater psychopathology, requiring additional assessment for safety concerns and psychiatric hospitalization than in years past. Anecdotally, many pastoral psychotherapists have shared that more of the individuals they are seeing now require and benefit from antidepressants, anxiolytics, mood stabilizers, psychostimulants, and other medications in addition to "talk therapy." These practice realities for both psychiatrists and pastoral psychotherapists have been present for some time and are unlikely to change – both psychiatric services and affordable psychotherapy are in short supply in many geographic locations. The "goodness of fit" for prescriber (physician) and therapist (religious professional) collaboration is obvious and of benefit to individuals served by both disciplines.

Mrs. A is a 75 year old widow active in her small rural congregation and community. She began psychotherapy with a local pastoral psychotherapist after the deaths of her husband and adult son in an automobile accident twelve years earlier. She benefited from an antidepressant prescribed by her primary care physician (PCP), and continued both psychotherapy and medication for anxiety and depression following her losses.

Mrs. A developed a kidney infection, followed by complications of delirium and stroke. Though her recovery was significant, her therapist noted slowness of speech, a "dampening" of mood and energy, and pervasive fatigue. The therapist contacted a psychiatrist at a tertiary care medical center two hours from Mrs. A's home. After a thorough in-person evaluation, the psychiatrist coordinated a care plan with the pastoral psychotherapist and local PCP to optimize psychopharmacologic treatment and other supportive therapies in accordance with changes in her medical condition and advancing age. The psychiatrist will see Mrs. A for ongoing consultation twice yearly.

2. *General or informal sharing of information*. This may occur between individuals and groups, casually or informally, in verbal, written, or virtual formats. As noted above, mental health clinicians are well-advised to take several minutes to research the variety of faith traditions in the geographical area where they practice, as should counselors working alone or in counseling centers. The same applies to staff of larger churches, who should familiarize themselves with nearby parochial and other faith-based or associated primary and secondary schools and colleges, seminaries, graduate schools, and clinical pastoral education (CPE) programs. All of these are potential resources when questions arise in one's work regarding the religious beliefs, practices, and traditions relevant to the care of individual patients and families, or the religious/spiritual implications of larger societal issues such as terrorism, racism, LGBTQ+ acceptance, and coping with economic stresses. Similarly, clergy and pastoral professionals are often interested in receiving the most up-to-date information about psychiatric diagnosis, psychopathology, and medications their clients might be prescribed. Psychiatrists can share information about day treatment and inpatient psychiatry programs, substance use treatment options, rape crisis centers, resources for victims of sex trafficking, information about suicidality, and other concerns. While

detailed conversations around specific clients may be precluded in some contexts due to privacy considerations, general discussions of topical content can be quite helpful. In addition to one-to-one conversations, professionals of one discipline can invite the other to staff and faculty meetings for "meet and greets" to share what they do and how they might work together, in addition to giving talks on subjects of interest. Psychiatrists can prepare and share resource sheets with helpful information, toolkits, and web resources, with pastoral care and religious professionals doing the same.

A large metropolitan area is home to multiple seminaries with pastoral care training programs, a medical center with psychiatric services across the full continuum of care, and psychiatric residency and fellowship programs. A core group of twenty pastoral counselors knew each other from their training experiences two to three decades previously, and met regularly for group supervision and continuing education. Over recent years, they have noted that they were seeing more clients with psychotic symptoms, suicidality, borderline personality disorder, and severe substance use issues – none of which they had encountered in their training and early years of practice. They attributed the increased psychopathology to the closing of partial treatment programs, retirements of psychiatrists in the community, and changes in insurance coverage that tended to limit provider options for these individuals.

The pastoral counselors felt both under-equipped to care for these clients as well as they desired, and committed to providing much needed services not available to many elsewhere. They contacted a faculty psychiatrist at the nearby medical center. The psychiatrist appreciated the role the pastoral counselors provided in the care of many disenfranchised patients in the community, and worked with the peer supervision group to integrate them into appropriate conferences and opportunities in existing training programs, and connected the therapists with colleagues interested in consulting about complex patients and providing medication management. These collaborations inherently improved care for clients in need and expanded the knowledge base of pastoral counselors about the severe disorders seen with increasing frequency in their outpatient practices.

3. *Formal programs and conferences*. Information sharing may occur in larger, more formal settings. For instance, one of the authors recently organized a 6 hours program titled "Hot Topics in Child and Adolescent Psychiatry for Clergy and Religious Professionals." Held in the community room of a large, local synagogue, the day started with coffee and donuts. Talks were provided on youth suicide, cannabis (including medical marijuana and vaping), and LGBTQ+ basics for clergy. Each topic was discussed by junior members of the child and adolescent psychiatry faculty at the children's medical center, providing them experience addressing informed, medical laity in religious communities desiring more information on these challenging topics. Ample time was allotted for discussion before the next talk. A luncheon of sandwiches, salad, fruit, and a dessert was followed by a panel of religious professionals representing Christianity, Judaism, and Muslim faiths who responded to the mental health content from the perspective of these religious traditions. Thanks to an anonymous donor, the cost per person was $35, and anyone who was unable to afford the fee was welcomed warmly – all who expressed interest were able to attend. The conference audience represented all major traditions from the region, congregational leaders, pastoral counselors, seminary professors and students, and teachers and counselors from faith-based schools. The formal program was well-received, and the

informal conversations were rich, leading to requests for this type of programming to be offered on an annual basis.

In January 2021, this concept was adapted for implementation during the COVID-19 pandemic. The Children's Hospital New Orleans departments of psychiatry and pastoral care hosted a 3 hours virtual conference for clergy, religious institutions, and related others about anxiety, depression, and stress/trauma affecting children, adolescents, and families during the pandemic. Speakers represented psychology, psychiatry, and pastoral care from Children's Hospital, Louisiana State, and Tulane Universities. Attendees posed questions through the Zoom chat box, and the program was recorded and posted on the hospital's website for future viewing.

4. *Pitching in together during times of crisis and tragedy*. While this sharing of information should preferably be ongoing, local and national tragedies can bring both fields together quickly to work collaboratively in the face of unpredictable pain, loss, and sorrow. One of the authors, for instance, has been part of a team of mental health professionals and local clergy who worked together after an unforeseen natural disaster led to the deaths of several adolescent scouts on a camping trip. Family members, surviving peers in the troop, scout leaders, the congregation sponsoring the scouting programs, local schools, and so many others were devastated by the loss. Other examples of local crises included revelation of sexual abuse, school shootings, tornadoes, fires, and untimely deaths – all situations requiring impromptu working together and sharing discipline-specific expertise on the ground. National crises present additional challenges, often with political and economic overtones, but still urgently need the care, healing practices, practical assessments and interventions, and modeling of understanding and compassion that multidisciplinary collaborations are well-positioned to provide. In the immediate aftermath and months following the events of September 11, 2001, psychiatrists, psychologists, local clergy, pastoral care providers, local religious congregations, and students and trainees in mental health and religious professionals converged in New York City, Washington, DC, and in towns in rural Pennsylvania – indeed, across the country, to care for those most immediately affected by the downing of the doomed flights that day. All across the United States, mental health workers offered their expertise to churches, synagogues, mosques, and religious schools, and religious professionals from many faith traditions sought to educate others about the actual beliefs and practices of world religions. Other collaborations have occurred regularly during large-scale events such as bombings, shootings, tornadoes, earthquakes, floods, fires, blizzards, and hurricanes. In these situations, psychiatric physicians, mental health providers, and clergy, lay leaders, and pastoral care providers brought together the unique and shared gifts of their vocations of service.
5. *Students and trainees*. As mentioned earlier, the importance of curricula that stress multidisciplinary viewpoints and collaboration, and role modeling by instructors and admired mentors, is invaluable for future, healthy multidisciplinary collaboration. Medical schools, graduate schools, seminaries, and clinical training programs are increasingly emphasizing these practical "in the field"

training experiences. All future care providers and those to whom they will minister and care for in the future will benefit when young helping professionals experience the value of cross-disciplinary collaboration early in their professional lives.

6. *Multidisciplinary services at the organizational level*. The inclusion of esteemed community members on the boards of hospitals, charitable organizations, schools, and other foundations has been commonplace for decades. Clergy are now included on healthcare ethics committees and institutional review boards overseeing medical research, and mental health professionals. Physicians and mental health professionals are increasingly included on boards and in key advisory positions of religious schools and service foundations. The multidisciplinary conversations at these highest levels set the tone for respect and collaboration at all levels of organizational structure.

## The World After COVID

Given our current experience of living with COVID-19 and the limitations this has created for in-person work, the new normal has become virtual conferencing and distance learning. This is opening unforeseen possibilities for ways of doing therapy and reaching heretofore underserved populations. Several websites that discuss teletherapy make references to addressing the needs of those in underserved areas, such as rural parts of the United States, and others discuss the ethical questions this raises. But it also presents an opportunity for collaboration between clergy and mental health professionals who do not reside in the same geographical area but who could be resources for each other. Conferences of mental health providers and clergy conferences should begin to explore what collaboration along these lines would look like by creating online connections.

The implications of the pandemic for mental health and spirituality, including the effects of psychological health on spirituality/religiosity and vice versa, invite the reflection and care of all mental health clinicians and religious care providers. The sheer numbers of individuals who are suffering from the short- and long-term medical and emotional effects of the illness, the thousands who have died, and the millions of people worldwide mourning the loss and new morbidities of their family members and friends have been unfathomable. The increase in anxiety, depression, post-traumatic stress disorders, substance use, domestic violence, and child abuse documented during COVID-19 is alarming beyond measure [49–53]. Due to the intertwining relationships of spiritual and mental health, these issues have required the collaborative efforts of compassionate, well-trained providers from all disciplines within medicine, mental health, parish clergy, pastoral theology, and spiritual care in order to provide optimal and holistic care for individuals, families, communities, and nations.

Collaborating clergy and mental health clinicians must not forget financial and "worldly" considerations while providing care during these challenging times. The

economic effects and consequent loss of jobs, homes, and financial security are resulting in suffering that requires the empathy and care of psychiatrists, therapists, and clergy [54]. People of faith are mourning the loss of corporate worship, fellowship, public expression of rituals and rites of passage, and spiritual, emotional, and financial and material support provided in the context of congregations that are not able to gather together without placing their most treasured communities in medical danger. More than ever before, the church needs psychiatrists and other mental health clinicians embedded in and intimately familiar with the history, traditions, rituals, and psychodynamics of Christian faith communities. Similarly, the mental health field needs the wisdom of pastoral professionals steeped in the virtues and sensitivity to existential concerns addressed by religion and spirituality that are too often missing from other models of biopsychosocial care.

## Conclusion

Despite historical challenges and tensions, mental health and religious professionals have developed a number of ways to work together on behalf of individuals suffering from mental illness and their faith communities. Unpredictable and changing social conditions call for creativity and initiative to meet the needs of these individuals and promote the flourishing of both mind and spirit.

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# Chapter 16
# Principles and Practice in Educating Christians About Mental Health: A Primer


**Wai Lun Alan Fung, Mena Mirhom, Tom Okamoto, and Victor A. Shepherd**

## Introduction (Alan Fung)

> The best thing for Christian clergymen and psychiatrists is to do their best within their own roles. That means respecting each other's territory and not overstepping boundaries… Sometimes clergymen get uptight because psychiatrists are going around forgiving sin while psychiatrists get uptight about clergyman doing psychotherapy. –Dr. M.O. Vincent, Canadian psychiatrist

Dr. Vincent made these remarks in an article titled "Christianity and psychiatry: rivals or allies?", published in 1975 [1]. Nonetheless, these views are still often held by both psychiatrists and Christian clergy in 2021, despite a growing literature on education on mental health within Christian contexts [2, 3]. The statements by

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Dr. Vincent also led to lively discussions in the psychopathology course for the Master of Divinity in clinical counseling program that I [W.L.A.F.] taught a few years ago at the Tyndale University – a Christian university in Toronto, Canada, where I have been a research professor.

One of the required texts that I selected for this course was *Troubled Minds: Mental Illness and the Church's Mission* by Amy Simpson [4]. In the book, Simpson described a survey that she had conducted with over 500 Christian church leaders – which revealed significant mental health burdens that many Christian congregants were experiencing. Simpson advocated for increasing the awareness of mental health issues in Christian communities, and suggested numerous ways of doing so.

Another core text for the course was the American Psychiatric Association (APA) *Mental Health: A Guide for Faith Leaders* (including its accompanying *Quick Reference Guide*) [5], which is freely downloadable from the APA website. This invaluable resource was published in 2015 by the Mental Health and Faith Community Partnership. The Partnership was formed in 2014 by the APA Foundation and the Interfaith Disability Advocacy Coalition as "a collaboration between psychiatrists and clergy aimed at fostering a dialogue between two fields, reducing stigma, and accounting for medical and spiritual dimensions as people seek care" [6]. One of the aims of the Partnership was to "provide an opportunity to improve understanding of the best science and evidence based treatment for psychiatric illnesses among faith leaders and those in the faith community." While the Guide was not only focusing on a Christian audience, students in the Tyndale psychopathology course reported that a concise learning resource such as this was very helpful. Indeed, I have heard similar feedback about the Guide from numerous others in the Christian community.

A key element of success in any educational endeavor is how involved the learners are with the process – which is partly influenced by their engagement with the educator. As such, I had invited Reverend Dr. Victor Shepherd, a renowned Canadian Christian pastor and well-respected theology professor at Tyndale University, to be a guest lecturer at a session of the Tyndale psychopathology course. A dynamic and erudite speaker with decades of frontline experience working with individuals with mental health issues, Rev. Shepherd mesmerized the students in his hour-long lecture and empowered them to be proactive in addressing mental health issues as Christians. Course evaluations made it evident that Rev. Shepherd's lecture was a highlight of the course.

In the second section of this chapter, Rev. Shepherd elaborates on his perspectives concerning the mental health needs of members of the Christian community and how increased awareness may help. Indeed, with Rev. Shepherd and other mental health and spiritual care professionals, I co-founded the Working Group for the Promotion of Mental Health in Faith Communities (mentalhealthandfaith.org) in Canada – which has been involved in the organization of conferences, seminars, and other activities in promoting mental health focusing on Christians [7].

In the third section of this chapter, Dr. Thomas Okamoto, a California-based Christian psychiatrist with extensive experience collaborating with Christian churches – including the California-based megachurch Saddleback Church pastored

by Rick Warren – discusses some guiding principles for psychiatrists in teaching Christians about mental health, and provides some illustrative examples.

In the fourth section, Dr. Mena Mirhom, a New York-based Coptic Orthodox Christian psychiatrist, describes his mental health education experiences with members of the Orthodox Christian Church, utilizing the APA *Mental Health: A Guide for Faith Leaders* as a primary reference. In the final section of this chapter, I provide commentaries on selected themes arising from the earlier sections.

## A Pastor's Perspectives (Victor Shepherd)

As a pastor who has served, since ordination, in a Canadian mainline denomination, I [V.A.S.] have long noted that what the congregation or larger Christian community *perceives* and subsequently *does* depend almost entirely on the vision and activity of its leader. In other words, the pastor must first model the congregation's awakening to an urgent need, and then model a gospel-impelled engagement with sufferers. Although congregants have long been aware of those among them who are mentally ill, they tend to hold off doing anything on account of several considerations: their unvoiced suspicion that because they aren't professionally trained, there is nothing they can do, or their feeling of helplessness in the face of the mystery of much mental illness, or their outright fear that mentally ill people characteristically pose a threat to those who might otherwise receive them.

Ordained to the ministry of Word, Sacrament and Pastoral Care in 1970, I was assigned to a rural congregation in the poorest province in Canada. Upon arriving I found two other pastors my age, newly minted, and, like me, graduates of major seminaries whose academic integrity and theological soundness were indisputable. Yet I found within the first month of our shared venture in our village that I possessed an interest in and a concern about the mentally ill that my two colleagues not only lacked but also appeared not to want to acquire.

My colleagues, whose doctrinal orthodoxy and zeal were unquestionable, nonetheless one-sidedly reduced the complexity of human suffering to the category of the spiritual. They readily saw disturbed congregants as replete with spiritual problems. The suffering people in their midst needed to pray more, believe more, trust more, and "surrender" more – all of which magnified their guilt and inflated their anxiety. Already suffering from ailments that the current Diagnostic Statistical Manual readily identified, these people found their suffering compounded by pastoral advice that only added a religious burden to their psychiatric distress. Gently I asked my colleagues if they would proffer the same spiritual counsel to someone suffering from type I diabetes or a brain aneurism or a fractured femur. I insisted that to attribute all mental health issues to spiritual deficits was inaccurate, unhelpful, and even cruel.

Unlike my colleagues, in my final year of seminary studies (1970), at the University of Toronto, I had enrolled in a course, "The Human Person in a Stressful World," taught by a psychiatrist. Months later I emerged from the course not merely

with medical information that I had heretofore lacked, but I emerged with a new worldview, one I had not known previously to exist.

The "world" in which I was to dwell for the rest of my ministry was the complexity of the human person together with the multidimensionality that characterized the pervasive and relentless nature of human suffering. It was the configuration of the stresses, frequently swelling to distresses – intrapsychic, social, biological, historical, and religious – that bear upon people, together with the constellation of responses to such stresses. Some responses are individual (stress stimulates some people to greater achievement, while stress effects breakdown in others). Other responses are social (institutionalization, whether in a hospital or a prison, is one such social response).

In teaching me about the scope, profundity, and relentlessness of human suffering, the psychiatrist-instructor spared me a lifelong shallowness born of ignorance and spared me a simplistic, unrealistic approach to the people I would see every day for several decades in my work as a pastor. In the village to which I was appointed, I quickly found people suffering from a gamut of psychiatric disorders: depression, bipolar disorder, schizophrenia, obsessive-compulsive disorder, eating disorders, borderline personality disorder, psychopathy, and, not least, addictions. The impoverished area of Canada where I was ministering at the time had an incidence of alcoholism three times that of the national average – an illustration of the relation of specific kinds of psychiatric problems to socioeconomic stresses. Considering the above, I deem it essential that candidates for ordination be schooled elementally in psychiatric issues. Unless the congregation recognizes the pastor's sophistication in this regard, members remain immobilized.

More concretely, what assistance does the pastor or trained counselor or sensitive congregant most need immediately? All of these individuals need a ready-to-hand list of mental health professionals to whom to refer. While anyone at all may direct the sufferer to a counselor, in Canada only a physician or nurse-practitioner may refer to a psychiatrist. Having an acquaintance who is a physician or nurse-practitioner can help one procure appointments for those who would otherwise remain unattended to, and unrelieved.

Not merely the pastor but congregants more generally must understand that the issue for them is not how to treat (only the professionally trained can do this), let alone cure. Rather, the issue is how to respond. The first item in the Christian community's response is to appreciate that everyone suffers and that many psychiatrically ill people suffer atrociously. For instance, while I had quickly learned to categorize the alcohol-addicted person as a "funny-drunk, mean-drunk, or dirty-drunk," it was only when a recovering alcoholic (a clergyman temporarily on loan to the provincial department of social services) pressed upon an area-wide gathering of clergy that *the* characteristic of alcoholics isn't their obnoxiousness or bravado or denial or the distress they caused those nearest them that I learned it is their *suffering*. Underneath all the boasting and blustering, there is a pain that few have noted and fewer still have touched. The psychiatrist-instructor's word transformed my approach to the substance abuser of any kind, and it dispelled the disgust I had long felt toward those whose disgrace had loomed larger with me than their distress.

Late one afternoon, years later, I found myself visiting a congregant whose alcohol abuse had offended and angered several members of the congregation. Already I knew that a relative had abused him as a child; the store that housed his music-supply business had burned down and his business with it; his wife had left him; and his current wife had witnessed the fatal shooting of her first husband on the steps of a New York City hotel in a case of mistaken identity. That afternoon, as I spoke with him, his wife came home from work, found me with her intoxicated husband, and wept uncontrollably at her public humiliation. Quietly I said to her, "Your husband is suffering—and you are suffering no less." Whereupon she asked me, "Would you have supper with us?"

Addressing stigma is a major aspect of the congregation's ministry. What is the stigma? Historically, the stigma has been dreadful. In some cases, the ill person has been deemed uncommonly wicked. The psychotic woman who drowned her baby was regarded as morally deficient, and therefore meriting punishment. In other cases, the ill person has been deemed to be in league with the devil. The person with schizophrenia, for instance, who complained of "thought insertion" because he believed that he was being molested by forces outside him, was deemed guilty of satanic conspiracy. The treatment that people thought he needed varied. The sufferer was deemed a candidate for exorcism, or she was accused of witchcraft and was victimized unconscionably, or she was shunned and isolated since she was considered a spiritual threat to those uncertain about their own spiritual integrity.

More recently the mentally ill person has been regarded simply as uncommonly weak. She is told to smarten up and toughen up and grow up; to get control of herself; or to live like a responsible adult in an adult world. "Stigma" is a Greek word meaning "brand, scar, mark." The Christian community is mandated to undo this mark.

In identifying the suffering of the mentally ill person, a major feature of the church community's response is to reach out to that person's family. Anyone who has spent even 1 hour with a psychotic person whose world overlaps no one else's or has spent the briefest time with someone whose depression can lower the mood of any room grasps something of what it is like for family members to live with the mentally ill person day after day. In addressing the needs of the ill person's family, once again we must be aware that our mandate is not to treat, not to cure, but to respond. The response can be remarkably mundane. A woman struggling because of the emotional collapse of her husband told me the most helpful offer of assistance came from a fellow who offered to do what she could not do: mow weekly the expansive lawns surrounding her home. Does someone need transportation? A ride to the hospital for medical tests? Often the church community assumes that assistance presupposes discernment of the dramatic, when in truth the most concrete, material needs can be addressed much more readily.

At all times we must be aware of ubiquitous loneliness. In my seminary classes, I was told repeatedly that guilt (not the state but the feeling) was the besetting issue among congregants. In no time, however, I discovered that not guilt but loneliness was the most troublesome. Loneliness is devastating. Loneliness bends people out of shape. Pervasive, protracted loneliness will find people behaving in such a way

they could never have imagined. Such loneliness quickly complicates life, and spirals down into degradation and humiliation. The Christian community must remain aware that all of us, but especially those who are suffering uncommonly, are most vulnerable spiritually (we are extraordinarily prone to sin) when we are most needy emotionally. Loneliness magnifies susceptibility to spiritual collapse.

Simple hospitality is yet another means of ministering to psychiatric sufferers and their families. The pastoral epistles remind us that Christian leaders are to model hospitality, and the letter to the Hebrews insists that in exercising such many have received angels without knowing it (Heb. 13:2).

*Simple* hospitality must be underscored. Congregants are often reluctant to invite people into their homes because they feel underconfident: their cooking is not *cordon bleu*, their furniture isn't elegant, and conversation topics will be exhausted in 5 min. They fail to grasp the crucial point: suffering people (family members no less) crave having their isolation overcome. The quality of the meal or the elegance of the furniture or the erudition of the dinnertime conversation – none of this they care about or are even aware of.

It must never be thought that the Christian ministry more generally should be suspended with respect to the ill person. While mentally ill people may be suffering extraordinarily, and while their suffering differs from that of the person who lives with physical pain, their illness in no way diminishes their spiritual condition: the psychiatrically afflicted are nonetheless sinners, children of God by faith, and members of the congregation by love. In this regard the Christian community relates to them as it relates to everyone else. No doubt mentally ill people suffer in a manner that is unique to the psychiatrically troubled. At the same time, they sin like all of us in a manner that pertains to the spiritually troubled. For this reason, it must never be thought that the truth and reality of the gospel (the foundation and mission of the congregation) somehow are not relevant to them.

During my ministry, I have found severely troubled people who are fully apprised of their depravity are thoroughly aware they are held fast in the arms of the crucified, and who abound in the fruits of the Spirit. I have found severely troubled people who "love our Lord Jesus Christ with love undying" (Ephesians 6:24), and who display remarkable discernment (the chief manifestation of the Holy Spirit in the Book of Acts). To assume that someone cannot understand, respond to, and exemplify the gospel because she is mentally ill is only to demean her and intensify her suffering.

There always remains much that the congregation as a whole can do. Around the corner from the church building of the congregation that I served for 21 years was a group home that accommodated chronically ill people with a range of conditions, including the person with schizophrenia, the intellectually challenged, and the brain damaged (one of the latter, an engineering graduate of McGill University, was institutionalized following surgery for brain cancer and its aftermath). Several members of the congregation who had put their fear behind them decided we should treat these residents to a meal and an evening in a restaurant. We made sure to have on hand two congregants for every "guest," simply in case someone decompensated and the situation had to be dealt with immediately.

The residents rejoiced. They had been recognized and their humanity affirmed. Their Kingdom membership had been upheld by the Kingdom-sighted (Christians) where for years they had been shunted and shunned by the Kingdom-blind. In no time, the event was repeated, and then was repeated again, as a wider outreach expanded in proportion to the scope of suffering discerned. All such evenings were nothing less than an anticipation of the Messianic banquet, when everyone will sit under vine and fig tree, and no one will be afraid (Micah 4:4). For on that day every tear will have been wiped away from every eye (Revelation 7:17).

## Psychiatrists Teaching Christians About Mental Health (Tom Okamoto)

I [T.O.] and other Christians view Christ as the "Great Physician," and consider His acts of healing as primarily spiritual in purpose, accompanied by His teaching. He used healing to educate the afflicted and those observing that His spiritual authority commanded physical reality. These teaching moments were socially relevant and intimately personal, as the Healer created physical and emotional transformation toward spiritual growth. Psychiatrists who are of the Christian faith are called to follow in Christ's footsteps [8] including healing but also teaching.

Johann Christian Reil named the medical specialty "psychiatry" in 1808. The son of a Lutheran pastor, he envisioned psychiatry to include the care of the patient's psyche and soma, body, and soul [9]. The American Psychiatric Association presents a yearly "Oskar Pfister Award" for outstanding contributions in the field of psychiatry and religion. Pfister, a lay psychoanalyst-Lutheran minister, was a student of and friend to Sigmund Freud and promoted Christ as the "first psychoanalyst" [10]. Psychiatry draws from its psychoanalytic history and transdisciplinary identity rooted in the fields of sociology, philosophy, and theology to address the human experience. This holistic legacy undergirds today's psychiatry, advancing medicine and neuroscience while employing psychological, neuromodulating, and pharmacologic therapeutics.

Since the prevalence of mental illness is high [11], psychiatrists are often asked to give talks to general audiences, in order to provide psychiatric education, dispel misinformation, and destigmatize mental illness. The ethical standard of community service which applies to the psychiatrist as a physician includes providing psychiatric education for the world at large. Psychiatrists are called to engage in speaking opportunities whenever possible, developing a professional identity within a personal, community, and global context. Formal engagements to speak to professional medical and psychiatric organizations, parent-teacher organizations, or service organizations such as the National Alliance on Mental Illness and Mental Health Associations are clearly important opportunities for psychiatrists to educate.

In order to provide community education and a professional mental health presence, appropriate use of social media by psychiatrists is encouraged by the American Psychiatric Association, which offers training to psychiatrists to avoid missteps.

Blogs, vlogs, television, radio, and other media forms, formatted appropriately, can be useful if they maintain professional standards. Psychiatric teaching may be requested unexpectedly. Requests can come from neighbors, business associates, and the gym, from children's school activities, as well from places of worship.

Despite possible pitfalls, there are benefits in sharing general mental health information through social media to the church. Teaching on podcasts, video blogs, Christian television, or radio call-in shows are not appropriate venues for specific personal clinical assessment or treatment recommendations. This would violate the professional ethics standard specifically identified in the American Psychiatric Association's "Goldwater rule," ethics annotation 7.3, which states, "On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement" [12]. Aside from this ethical and clinical boundary, a psychiatrist can disseminate much-needed information including general disease facts as well as referral information. National support groups such as Alcoholics Anonymous and the National Alliance on Mental Illness can be promoted. Audiences can benefit from basic descriptions of medications and other treatments, and misinformation can be dispelled. Local medical or church resources can be suggested. This information can be very helpful, especially for those in areas lacking resources or technology.

Teaching is a complex profession that deserves full engagement. Psychiatrists typically have no formal speaker training other than prior experiences of good or bad teachers. When psychiatrists teach outside the medical environment, they do so without structure, formal curriculum, and academic credibility. Instead they are thrust into the public speaking world of "Ted" talks, stand-up comedy, and social media. Professional credibility can fade quickly in front of a public whose interests vary but often include a desperate need for personal clinical information about mental health. This can range from searching for a psychiatric referral to a need for information while in crisis.

When relating to an audience, psychiatrists can re-task clinical skills used daily in the clinical setting toward teaching. The therapeutic relationship can be reframed to help establish a teacher-audience relationship; psychotherapeutic interpretations and patient education can become part of the teaching content. Utilizing an "intersubjective third" process in psychotherapy (see below) can be reframed to promote active listening skills, encourage audience discussion, and create a transformative educational experience. Trust, empathy, connection, and understanding a patient are crucial elements in a positive, therapeutic relationship leading to more effective clinical outcomes [13], just as trust, teacher engagement, connection, and understanding the audience can enhance effective learning and personal growth in an educational event.

Addressing the patient "where he or she is" is important both in the doctor-patient relationship and in the teacher-audience relationship. In translating

psychiatric clinical skills to establish a teacher-audience relationship, two concepts can be helpful, bridging the two disciplines of psychiatry and teaching. One is the concept of "levelism," which recognizes varying levels of audience complexity. The second concept encouraging connection is "contextualization," aiding relational process through enhancing empathy.

**Levelism** Approaching an unknown audience can be a daunting task. Often psychiatrists are given little information about the characteristics and numbers of the attendees to whom they are to speak. One organizing concept that cuts across disciplines is the idea of "levelism," referring to differences in peoples' levels of knowledge, understanding, and abilities to learn. Speaking to teens about brain function and life trajectories among marijuana users requires different approaches and content from speaking to high school honor students who are training to be peer crisis counselors. "Levelism" is relevant to different fields of study, including psychiatry, and teaching, and can be useful in engaging audiences who appreciate these level differences being recognized.

In the field of education, Benjamin Bloom authored a taxonomy of education in the 1950s and 1960s in which he described hierarchic levels in cognitive, affective, and psychomotor domains, and a hierarchy of goals in each domain marked by increasing levels of complexity, progressive levels of knowledge, and understanding, informing current approaches to teaching [14–17].

Christians are familiar with the concept of spiritual levels of maturity, referenced in New Testament passages 1 John 2:12–14, where the disciple John addresses 3 different audiences, including children, young men, and fathers. Believers' different spiritual ages reflect different spiritual needs. In Ephesians 4:14–16, the apostle Paul describes the characteristics of "spiritual children" who "grow up" toward Christ. In 1 Corinthians 3:1 and 2, Paul describes the Corinthians as "mere infants," not ready for "solid food," only "milk," as they were not ready for advanced spiritual teaching.

**Contextualization** The concept of "contextualization" arose from studies in cross-cultural relationships, including sociology, linguistics, and education between the late twentieth century and the present. In the 1970s it was utilized in Christian missions directed toward those in other cultures [18]. Contextualization remains significant today as the "verbal and conceptual bridge over which students cross to learn new information being presented" [19]. It can be useful in teaching those with varying cultural backgrounds, levels of knowledge, psychological developmental levels, and spiritual perspectives.

In teaching, contextualization emphasizes ongoing assessments of efficacy including adjustments in techniques and content while teaching, just as psychiatrists adjust interpretations, monitor patients' reactions to interventions, and change approaches within a 45-min session. "Contextualization" fashions the content and process within a teaching event. It demands emotional and cognitive presence from the psychiatrist, and prioritizes interactive participation by the audience, allowing for more transformative learning.

**Intersubjectivity and the "Third" in Teaching** The concept of intersubjectivity and the "third" refers to relational phenomenon outside of the dyadic teacher-audience content exchange. Similar concepts are found in many disciplines, including sociology and psychoanalysis. In their social psychology paper, Gillespie and Cornish define "intersubjectivity as the variety of relations between perspectives. Those perspectives can belong to individuals, groups, or traditions and discourses, and they can manifest as both implicit (or taken for granted) and explicit (or reflected upon)" [20]. The concept of the "third" as "psychoanalytic third" by Ogden [21] denotes what transpires between psychoanalyst and analysand, including their interdependent unconscious and conscious content and process. When applied to education, use of the "intersubjective third" elevates teaching beyond Bloom's lower levels to a higher level of creating and transforming, which can include the spiritual. Psychiatric education to the Christian church can be provided by any mental health professional with psychiatric knowledge, including non-Christian psychiatrists. However, for psychiatrists educating the Christian audience, another dimension of teaching is expected. Bridging the two worlds of spirituality and science requires a wider vision, as both theology and psychiatry have different explanations for the nature of reality and humanity. A church audience will require spiritual congruence, tasking the speaker to provide psychiatric information that supports the audience-defined Christian beliefs. A psychiatrist who has Christian beliefs can bridge those separate themes within the context of his own professional, personal, and spiritual experiences. The psychiatrist with faith has a mediating role to play in bringing to the church the world of psychiatric care, bridging science and faith.

The current rapprochement between psychiatry and spirituality is driven by psychiatric research [22] that affirms that spirituality usually promotes mental health and illness recovery. Psychiatrists can now recruit and train spiritual communities to help those with mental illnesses. Psychiatrists can also bring to the church the "good news" that science offers effective medical treatment promoting individual healing and spiritual growth. Positive examples can be found from two Christian evangelical megachurches, who have committed themselves to mental health ministries. One is Fullerton Free Church, of the Evangelical Free denomination, in Fullerton, California, formerly pastored by the evangelical Christian writer, educator, and radio preacher Chuck Swindoll. Another church that has established its presence in mental health ministries is Saddleback Church, of the Southern Baptist denomination, pastored by the evangelical preacher and author, Rick Warren, located in Lake Forest, California.

Both churches include licensed mental healthcare pastors, producing multiple support and recovery groups including peer support counseling systems, structured with legal and psychiatric advisement. They have built clinical credibility and are used by local professional providers and healthcare systems as resources for patient support. Both churches enlist psychiatrists for staff and volunteer consultation, educational events for congregants, mental health conferences, and training of pastoral, ministry, care staff, and volunteers. Psychiatric education also includes clinical consultations and demonstrations of psychiatric interviews with consenting counselees.

This has fostered new awareness of the depth of psychiatric clinical information available, to the congregant in emotional pain as well as to staff.

The request to speak at a church can arise to promote a ministry, such as a recovery group or a preaching series on anxiety. It can originate from a traumatic church incident, including suicide, gun violence, or other trauma. The psychiatrist can be called to address immediate mental health needs to educate, support recovery, destigmatize mental illness, and promote further treatment when necessary.

***Christian Psychiatrists Employing the "Spiritual Third"*** Christian psychiatrists have an additional bond that they share with the audience of the faithful, that of the life of faith in Christ. The concept of "intersubjective third" can be applied uniquely to the Christian audience. Christians who gather together engage a "spiritual third," present within the spiritual dimension, functioning similarly to "intersubjectivity." Biblically, when "two or more are gathered (in Christ)" the Holy Spirit participates (Matthew 18:20). This shared experience can be claimed by the Christian psychiatrist, to invoke a spiritual process beyond his or her own professional focus.

Mediation through the "spiritual third" (Holy Spirit) connects the audience and psychiatrist in shared understanding and experience through intersubjectivity. It allows for spiritual contextualization that promotes a "higher-level" intimate learning experience. This undergirds the process of teaching and encourages a transformative experience.

**Christian Psychiatrist as "Third"** Mediation also requires the role of a person, another "third." The teacher, as mediator, elevates the student through the third process, transforming them to a higher level of understanding. For Christian psychiatrists, a church audience may require a limited basic level of depression and anxiety information, or request discussion of complex subjects such as healing, destigmatization, and the role of suffering in spiritual growth. Teaching opportunities occur in large church audiences in person or online, as well as in the individual therapy office, or even in the pews in Sunday morning gatherings.

An example occurred during a talk given at a Christian high school, where parents were lectured on anxiety and depression in their children. In the question-and-answer period, one couple shared their pain over their daughter's periods of depression and self-destructive behaviors, treated with courses of inpatient and outpatient care with medications. Their church was initially involved but clearly did not have the understanding to support the girl or her parents, who became marginalized with feelings of abandonment from the church and from God. This was described in painful transparency and vulnerability. Validation and support were immediately given by other parents in the room, and the discussion acknowledged limitations of care in treatment systems, and the ultimate fallibility of people and the pain that results. Support was generously given from the audience, and the church and the "spiritual third" became active in the room. Compassion and understanding elevated the lecture to a life-transforming experience through the power of community. Referrals and resources were given, and healing was palpable.

Effective therapeutic Christian education occurs daily within individual psychiatric sessions for pastors, church leaders, peer church counselors, and chaplains who are patients. For example, a seminary-trained, professional counselor was treated for lifelong mood symptoms. When medical treatments relieved depression and anxiety symptoms, his lifelong identity as a "spiritual failure" was reversed. Relief from painful symptoms released him from the daily pain of perceived abandonment by God. The persistence of psychic pain and the inability to feel joy were reframed as treatable medical symptoms instead of spiritual condemnation. This freed him to embrace the idea that God's love could be experienced as his mood disorder was effectively managed.

In conclusion, psychiatric education can redefine symptoms of mental illness as reflecting brain dysfunction, undoing a lifetime of shame and stigma held in self-loathing and condemnation. The Christian psychiatrist can share the "good news" that these symptoms can be treated medically, understood psychologically, and redeemed spiritually, and thus ultimately healed within a model of Christian sanctification.

## Mental Health Education in the Orthodox Christian Church (Mena Mirhom)

From my [M.M.] perspective, the primary goal of the educational campaign in the Orthodox church over the past decade has been to show that there is true harmony between the role of faith and the role of mental health professionals. The mutual distrust that often exists between the faith community and the psychiatric community begins to decrease through sincere educational initiatives. The trainings have taken place in person and online. We have been able to hold educational programs across several major cities in the United States and Canada. They are often hosted by individual church parishes or diocese. At times, they are also hosted by Orthodox Christian healthcare organizations that serve as a type of liaison between the church and the healthcare community.

The trainings are often structured as 1-day conferences or individual lectures that cover a variety of topics that include serious mental illness, common mental illness, as well as substance use disorders. The faculty involved in these lectures come from an Orthodox Christian tradition that is rich in the study and understanding of the role of the mind. This tradition is combined with modern training and credentialing that bridges the gap between faith and psychological health. The intent is that after each lecture or conference, the attendee walks away embracing a more complete understanding of the biological-psychological-social-spiritual model of care.

***Materials Used*** The primary text used in the educational endeavors above was the publication by the American Psychiatric Association's Mental Health and Faith Community Partnership, discussed earlier above [5]. The content is geared toward faith leaders and has been well received by attendees and faith leaders. The lecturer

will often have to take the foundational content and tailor it to the Orthodox jurisdiction. Several core topics are covered.

**Understanding Health and Disease** The core theological understanding of disease or disorder in the Orthodox church is connected to the fall of man that resulted in the ultimate separation from the source of life. It is then in the return to the Creator that one can begin to find health of the soul, body, and mind. A significant component of this return is to use the tools made available by God, which include biological, psychological, social, or spiritual modalities. Disease or disorder is thus not understood as a personal weakness, character defect, or a product of individual sin. Healing is also seen as a divine gift that is manifested through the use of earthly tools. Any seminar or training that we conducted needed to begin by a more in-depth understanding of this framework.

**Red Flags Warranting Attention** One of the primary elements that are covered in each of the trainings is understanding red flags and potentially dangerous issues that may come up. Being able to recognize and take the first steps to addressing suicide is one of the most important areas of discussion. Because making a diagnosis is complex, the trainees are discouraged from trying to commit to any diagnosis but rather to recognize the need to connect an individual to care.

**Understanding Common Mental Illnesses** This section focuses on understanding the overlap between the clinical symptoms of anxiety and depression, with the spiritual understanding of despair, despondency, or fear. We begin by reviewing the patristic and ancient Christian understanding of the soul. We review several biblical characters who encountered moments of deep despair and how they navigated those struggles. For instance, in the Old Testament, the prophet Jonah said "It is better for me to die than to live" (Jonah 4:3). We also discuss the New Testament passage where St. Paul the Apostle said, "we were burdened beyond measure, above strength, so that we despaired even of life" (2 Cor 1:8). Through this module, we demonstrate that the experience of severe anxiety or depression is in fact seen across the biblical narrative as well as the church history. Therefore, this further enables the participant to see that there is no shame in the engagement of treatment of the spiritual as well as one's biological or psychological nature.

**Understanding Serious Mental Illness and Psychosis** Distinguishing religious preoccupation from psychosis can often be challenging in the clinical setting as well as in the community. This section first reviews the spiritually and culturally understood but unique phenomena seen in nature such as apparitions or exercises. Acknowledging the existence of such experiences while placing them in context allows us to "test every spirit" as 1 John 4 tells us.

**Understanding Substance Use Treatment** In this section, we underscore the understanding that substance use is not a moral failure but rather a treatable disorder that can be approached with medication and therapy, as well as by profound spiri-

tual intervention. This is often once of the most eye-opening sections of training as participants are introduced to medication-assisted treatment, harm reduction, as well as motivational interviewing.

**Supporting Family Members** The burden of supporting individuals with mental illness can often feel isolating. In this section, participants are introduced to local and national resources that empower families in their effort to support loved ones struggling with mental illness.

**Creating a Safe Space to Decrease Stigma** Lastly, because this is an ongoing effort, we focus on how each parish can create a safe space. This includes the adding content to regularly scheduled sermons and youth meetings as well as posting resources to community mental health organizations. One of the most encouraging elements of this program has been the leadership of the clergy which enables a culture change to take place in parishes. Their embrace of mental health education has proven to be a lifeline for families and prisoners.

**Response and Feedback** In the early years of the educational campaign, there was understandable resistance and uncertainty. Over time, the community began to see that the team is in fact invested in the long-term educational initiative. It became apparent that this initiative would indeed not replace any current spiritual interventions but rather compliment them. The resistance slowly turned into appreciation and collaboration. The educational curriculum began to empower faith leaders of various levels to deal with practical challenges encountered daily within the parish. Our hope is that this initiative will continue to expand to each parish in North America, Australia, and Europe. We are also collaborating with Orthodox parishes across several jurisdictions in order to share resources, experiences, and vision.

## Commentary and Conclusions (Alan Fung)

In this chapter, authors have outlined rationales, guiding principles, and some practical examples of how one could approach mental health education in various Christian communities. Our scope has been illustrative rather than exhaustive. In this final section, I [W.L.A.F.] will briefly elaborate on three of the areas discussed/alluded to in previous sections: online resources, cultural sensitivity, and the training of psychiatrists/trainees.

**Online Resources** Mental health education materials available online (especially if free of charge) can significantly enhance the reach and impact of educational endeavors. The aforementioned *Mental Health: A Guide for Faith Leaders* (and accompanying *Quick Reference Guide*) is freely downloadable from the APA Mental Health and Faith Community Partnership website (www.psychiatry.org/faith), together with other resources. For materials specifically targeted for Christians, an excellent source is the Mental Health Ministries (www.mentalhealth-

ministries.net), founded by Rev. Susan Gregg-Schroeder, a Christian clergy and a person with lived experience of mental health issues.

**Cultural Sensitivity** Some of the work discussed in the section by Dr. Mirhom [M.M.] in the context of Coptic Orthodox Church addresses this issue. Cultural sensitivity and competence are important considerations in mental health education endeavors for Christians. For instance, in providing mental health education seminars to Chinese Canadian Christian churches, I often use sleep health and issues as a gateway to further discussions on mood, anxiety, and other mental health conditions – due to the tendency of somatization, as well as sleep disorders being less stigmatized than mental health disorders in the Chinese culture [23]. There is also significant resistance among many Chinese Canadian Christians to engaging in mindfulness-based interventions – due to the beliefs that these are associated with the Buddhist tradition. As such, in my mental health educational endeavors for Chinese Canadian churches, I often discuss with the audience Christian-oriented mindfulness interventions. Indeed, as part of the international Bridges Consortium for spiritually integrated psychotherapy (funded by the John Templeton Foundation) – the *Christian-based Spiritually-integrated Psychotherapy for East Asians Research Initiative of Toronto* (CSPEARIT) was formed in 2017 to utilize practice-based research methodology to investigate the use of Christian-based spiritually integrated psychotherapy among East Asians in the Greater Toronto Area, which I helped to establish [24].

**Training for Psychiatrists/Trainees** Psychiatrists and trainees must be trained to provide mental health education for Christians. As discussed above in the section by Dr. Okamoto [T.O.], psychiatrists can play a major role in mental health education for Christians. While the World Psychiatric Association and national psychiatric associations have also encouraged psychiatrists to consider collaborating with leaders/members of faith communities in support of the well-being of their patients [4, 25, 26], internationally there have been a paucity of educational endeavors focused on teaching spiritual/religious competencies to psychiatry residents [27]. As such, more training should be provided for psychiatrists and trainees in delivering mental health education to faith communities, including Christian communities. Such training should also encompass ethical considerations in providing mental health education for and in collaborating with members from faith communities [28, 29].

In conclusion, authors of this chapter have illustrated how various strategies may be employed in mental health education for Christians. We now appeal to *you* – readers of this chapter – to act *now* in contributing to these efforts.

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# Chapter 17
# Called to Lead?


**Jamie Hacker Hughes**

## An Initial Calling…

I was always going to become a maxillofacial surgeon. A rather obscure and specific vocation, but one whose roots were in fact very clear.

At the age of 2, I was diagnosed with a bone tumour (an *eosinophilic granuloma*), in my right humerus (the bone in the upper arm). Luckily, the GP to whom my parents quickly took me after I had begun expressing pain when being touched on my upper arm during a bath referred me straight away to the general hospital closest to where I was born in Cheshire. By nothing less than a miracle, the orthopaedic consultant at Manchester Royal Infirmary who accepted the referral, Mr. David Lloyd Griffiths, had just returned from an international meeting discussing this then rare condition, alongside others.

He knew exactly what he had to do and did not waste any time. He removed most of the humerus between the epiphyses (growing plates) and then did the same with the tibia (the long bone in the lower leg) before transplanting the bone from the tibia to the upper arm and then effectively removing a slice from my mother's pelvis before transplanting this into my lower leg. I was then encased in plaster from foot to wrist and remained so for the next 9 months. The operation, and my recovery from it, was nothing less than a miracle. All of this, understandably, did create quite an impression on a 2-year-old child, and I have several, although surprisingly not in any way traumatic, memories of that time. I had regular follow-up appointments with Mr. Lloyd Griffiths until I was finally discharged at the age of around 11 when he gave his full permission for me to go (theoretically, at least) on a school skiing trip.

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This explains the vocation to become a surgeon, which seemed to be confirmed through prayer. I attended school chapel from the age of 8 (and Sunday church with my parents before that) and was confirmed into the Church in Wales at the age of 10. The specific vocation to become a maxillofacial surgeon, though, came much later. The fact was that I didn't work hard enough for my A levels (the exams that high school pupils take to matriculate into universities in the UK). The grades that I attained in physics, chemistry and biology were just not good enough to get me into medical school (although it was a pretty close miss), but I discovered that they were just high enough to get me into dental school and that, also, if I completed my studies in dentistry and gained a fellowship in dental surgery, I could then go on to study medicine, gain a fellowship in surgery and become a maxillofacial surgeon.

No one in the general population had, perhaps, really heard very much about maxillofacial surgery until in the early 1980s when the Glasgow-based plastic surgeon, Professor Ian Jackson, became known the world over for the hundred or so operations that he performed on David, a boy rescued from a Peruvian hospital and suffering from a disfiguring disease, *noma*, born with no upper jaw, no nose and no teeth.

The plan was that my studies were to be sponsored by the British Army and then I would pay them back by serving as a dental or medical officer in the Royal Army Medical Corps before progressing with a surgical career. But the plan never saw the light of day. In a nutshell, I was pretty useless at dentistry, and so the dental school and I parted amicably 2 years into the course.

So, what was I to study? My wanderings around the university campus led to the psychology department where I saw a poster of a young woman in a white coat holding a clipboard bearing the words, 'Do you want to be a clinical psychologist?' An answer to prayer?

I decided that I did (anything to get me into a white coat, although I later discovered, however, that the only psychologists I was ever to meet who did, in fact, wear white coats came from Saudi Arabia and the Czech Republic). Anyway, the school of psychology readily accepted my transfer. But there was one, rather major, snag, however. The Local Education Authority decided not to give me any further grant funding.

So what was I to do? The solution was obvious. I had always been obsessed with all things military ever since I was a little boy. My parents had served in the Second World War, my grandparents in the First World War, and my great great great grandfather had fought at the Battle of Waterloo. The British Army was in my blood, and if they were not going to have me as a dental or medical cadet, well, they were going to have me anyway.

## Serve to Lead

I signed on at my local recruiting office to join the cavalry regiment of Wales, and the Border Counties, 1st The Queen's Dragoon Guards, went through the first Recular Commissions Board available and arrived at the Royal Military Academy Sandhurst in January 1978 for officer cadet training. The motto of the Royal Military

Academy Sandhurst is 'Serve to lead'. Officer cadet training is based around training as an infantry soldier, and during the period of the initial training course, in addition to the theoretical and academic studies, the cadet serves on training exercises in as many roles in an infantry platoon as possible: as a rifleman in a section, as number 2 on the light mortar, anti-tank gun or machine gun, and, eventually, in command of a 10-man section and, finally, the whole 30-man platoon.

'Serving to lead' is an ingenious and proven concept and tied in strongly with the Christian religion in which I had been raised as a toddler (I have always described myself as a 'cradle Christian', and the family practice of prayers around my bedside went back as far as I am able to remember, and beyond, quite possibly) and which I then continued as a cathedral chorister and through the rest of my school and university career to that point. At the end of training at Sandhurst, graduating officer cadets are ready to take up their first commands with their regiments or battalions but all of them having had the vital experience of what it is like to 'serve and be led'.

I had only signed on for a short service commission, and, so, after time spent in further training in the UK, armoured reconnaissance troop leading in the Cold War BAOR (British Army of the Rhine) and leading an infantry-role patrol troop in H-Blocks era-Northern Ireland, I left the army with not much of a clue as to what I was going to do. Fortunately, there was an organisation, the Officers' Association, which helped officers leaving the army to find employment, and I quickly obtained a position selling computers to lawyers. I knew nothing about computers, and next to nothing about lawyers either, although my brother was a barrister, but I discovered that I was, in fact, rather good at it and so I progressed from one company to another with greater and greater management responsibility, selling larger and larger computers. But at the end of 5 years, I was completely and utterly bored. So, what next?

After considering a number of options, including the church (training for ordination was something that I considered at regular points throughout my career, and at one point I came very close to it), I suddenly remembered all about psychology, and that advertisement, and from that point set out without delay to train to become a clinical psychologist by taking a 90% cut in pay to work as a nursing assistant at the Maudsley psychiatric hospital in London, following in the example, and with the strong encouragement, of my wife to be.

And this is where it all begins to make sense. What better introduction to studies in psychology than a short period of study at medical school covering anatomy, physiology, biochemistry, histology, embryology and pathology? I was probably to become one of the very few psychology students who had carried out a full dissection of the brain and cranial nerves. The earlier parts of my journey were to be, as it turns out, incredible assets in my developing vocation. From then on, the path became simple and straightforward, and I had a definite sense that I was firmly and truly on the path that I was intended to be on.

I loved my psychology studies at University College London (UCL) and was fortunate, very fortunate indeed, to gain a much sought after place to study clinical psychology at Cambridge. It was there, after a departmental lecture, that I first started thinking about military psychology, and the treatment of shellshock and post-traumatic stress disorder thereafter became a lifelong interest of mine. (My

interest in the trauma that follows disasters and major incidents had been kindled by the Aberfan disaster of 1966 where a colliery spoil tip collapsed just 20 miles away from my school, killing 116 children of around my age, and 28 adults, as it engulfed the primary school in the village below. My mother, a director of the local Red Cross, was there with her team of nurses throughout the aftermath, and my father was there too, volunteering to help in any way that he could).

On leaving Cambridge, I worked in the National Health Service as a clinical psychologist, initially with people with learning disabilities and then in adult mental health, developing a clinical practice in the assessment and treatment of trauma. As a Christian, and without my patients' knowledge, I often offered (as, indeed, I still do) silent arrow prayers regularly during difficult sessions with challenging patients, along with silent prayers of thanksgiving, but, whenever I was asked about my faith, I always answered openly and honestly. To pray openly would not have been acceptable, but here was a way, apart from through my clinical practice itself, in which I could exercise my faith.

## A Wounded Healer?

Five years after qualifying, I was working as a principal clinical psychologist in a joint health service and social services community mental health team. The caseload was large and the complexity of the problems that my patients were presenting with was significant. My caseload consisted of patients with severe and resistant depression, personality disorders and, my special interest, post-traumatic stress disorder. In addition to this, I was, by now, also developing a private practice and so saw private patients two evenings a week after my health service clinics. One way and another, it had been quite a stressful year, and I was now the only breadwinner in the family as my wife was still caring for our young son. At the beginning of the year, after a particularly cold Christmas, we prepared to move house (from a house where we had been very happy to a new house that came with my wife's new job).

My wife was, and is, a priest in the Church of England, having received her vocation just after we married and while I was completing my undergraduate studies in psychology. We trained together at Cambridge, she in theology and I in clinical psychology, and when I began work as a newly qualified psychologist, we moved into her first parish where she served as curate. We have always worked as a team with my taking up a variety of roles in the parishes in which she has served (crèche supervisor, choirmaster – several times over – Sunday School teacher and youth leader). It was during our time in my wife's first parish that our son was born, and, the following year, we left the parish to move into the little house from which we were now to move again into the one that came with her new post.

On any life events rating scale, though, my score would have been extremely high. As the date of the move to the house that came with my wife's new post as a cathedral chaplain approached, my sleep suddenly began to alter drastically with early-morning waking at 2–3 a.m., and consequent exhaustion. The GP prescribed

hypnotics, which did not work in the slightest, another GP increased the dose, and the accident and emergency department psychiatrist then prescribed some SSRI antidepressants, which had an effect, but a drastic one. My mood started yo-yoing, minutes at a time, and I became regularly and acutely suicidal, constantly planning, and at one stage very nearly attempting, to take my life. Fortunately, through my wife's intervention, I saw a consultant psychiatrist who prescribed an old-fashioned tricyclic antidepressant, which had an immediate positive effect. This was not without pain, however. Psychological problems have traditionally carried a very high degree of stigma, often self-stigma, and so I found myself mortified to be asked to go and see the psychiatrist in a unit shared by many others of his psychiatric colleagues, many of whom I cooperated with regularly in my private practice. So full of shame was I that I even hid in a cupboard until the time of my appointment. But I emerged from the closet, both literally and metaphorically, and within weeks I was symptom-free and on a phased return to my work, where all of my colleagues were, of course, and despite all my fears, amazingly accepting, understanding and supportive. God had, over the past weeks, seemed very remote and far off but had, of course, been there all along.

So all was well, at least until the next year, where, at around the same time of year, I relapsed with a further episode of major depressive disorder. So, back on the tricyclics (along with all the lifestyle interventions, of course), I recovered, again, very quickly, and returned to my work. But I must have remained on the antidepressants too long because my mood rose, gradually, steadily, completely uncontrollably. One day, in peer supervision with a psychologist colleague, I found myself telling her that I had to go because I had to climb into a spaceship with my 5-year-old son, and fight the Third World War… something was clearly not right! More delusions followed: that my wife was the Virgin Mary and my son the Messiah. My psychiatrist quickly diagnosed hypomania and put me on an antipsychotic which quickly restored my sleep pattern and my sanity. Two years after my first depressive episode, I was diagnosed with type 2 bipolar disorder (manic depression) and placed on lithium prophylaxis as a mood stabiliser. I have continued on this medication since then and have been really well ever since.

So, it seemed that I had been called not just to be healer but to be a wounded healer, an incredible privilege.

## Called to Serve

Ever since graduating, I had pursued a 'crusade' with the Ministry of Defence about the British Army again having clinical psychologists in uniform (they had not done so since the end of the First World War). Eventually, and through a series of coincidences, I was contacted by the person who had been recruited to develop clinical psychology services within the military (and who, to my amazement, was incredibly understanding of, and sympathetic with, my psychological condition about which I had been totally honest about when I applied to with the Ministry of

Defence), and thus I joined the Defence Psychology Service, initially on a part-time, but soon afterwards on a full-time basis. Although British Defence Mental Health Services had existed, in one form or another, since the First World War, psychological problems arising from warfare date back thousands of years, and the term 'post-traumatic stress disorder' only originated directly as a consequence of the Vietnam War.

Again, what better preparation could I have possibly had for the role of a military psychologist than my studies in psychology, my time in the NHS and 4 years spent as a young army officer? I had, it seems, been called to serve.

I initially worked carrying out neuropsychological tests on helicopter engineers who had been involved in contact with potentially toxic substances, and then worked therapeutically with, among others, traumatised paratroopers who had seen service in Bosnia, Kosovo, Macedonia, Iraq and Afghanistan. The number of troops returning from these combat zones was high. My interest and expertise in treating traumatic stress continued developing. Later, and in the company of psychiatrist colleagues, I was able to travel to all of these places and to meet and treat, among others, many highly decorated soldiers in the British Army.

## Called to Lead

After 3 years leading a defence mental health military research team at King's College, London, I was selected to lead military psychology for the Ministry of Defence. Again, what better preparation could I have had than my psychology training and experience in and outside the military, my previous business management and leadership experience and my time spent as a soldier?

This time, I realised, I was being called to continue serving but that also that I was being called to lead. I love languages and was very privileged during that time to be able to spend time on international projects the length and breadth of the world, forming some wonderful friendships with international colleagues from NATO and Partnership for Peace Countries, many of whom are still friends.

Eventually, however, I realised that I had reached my glass ceiling within the Ministry of Defence, although having, along the way, become the first ever Consultant Advisor in Psychology to the Surgeon General and having achieved my dream of persuading the British Army to commission clinical psychologists in uniform. I had been truly blessed.

On leaving the Ministry of Defence, my local university very generously made me a visiting professor, and they seemed keen for me to talk to them about the possibilities. East Anglia, where the university was based, was the home of 16 Air Assault Brigade (the army's busiest brigade since the Second World War) as well as of several Royal Air Force bases. It followed that, as people left the services, they settled locally, and so there was a large local ex-military veteran population. The university was persuaded to establish an institute researching into military veterans and their families as well as developing a number of courses in the area. God had, it

seems, put me in a place where my business experience, my military background and my research experience were all substantial assets. I had, once again, been called to lead.

After that, I stood for election and was elected as President of the British Psychological Society, the learned society and professional organisation for the UK's 60,000 psychologists. I led them in change and development programmes and forged international connections around the world. I also led the formation of the Society's first Presidential Task Force for refugees and migrants. In all of these latter roles, I was incredibly honest and open about my psychological history and my faith, and, as BPS President, I found myself incredibly well positioned to lead an anti-stigma crusade. Indeed, I edited a book on the subject [1]. In the years that followed, I was also elected to lead a religious organisation in Europe, the Third Order Franciscans, which I had belonged to throughout my career as clinical psychologist.

I now work in the independent sector, doing pro bono work with refugees' organisations alongside my private trauma work, and I am listening for what the next call might be. As it turns out, I realised that I have been specialising for over 25 years in the treatment of post-traumatic stress arising from people who have been involved in accidents, crimes, wars, disasters and catastrophes, and specialising in a method of treatment called EMDR (eye movement desensitisation and reprocessing). I had, it seems, been spending all of this time putting people back together again after all, but just not in the way that I had first imagined…

Vocations can come in many ways – as a flash of insight, through a nagging developing idea, through the examples of others, as a result of life experiences and often through a combination of all of these. But in my experience, I was led, in faith, carefully, although in what seemed at the time to be a haphazard way, into my career as a consultant clinical psychologist specialising in trauma, called to serve, serving, serving to lead and being called to lead as a wounded healer. Each step had prepared me for the next one, and with each step the call had become louder, clearer and stronger. Many, I am sure, will be able to tell a similar story.

## So: What Is Christian Psychology and Who Are These Christian Psychologists?

One can almost certainly say that, as Christian psychologists, we have been called – called to serve, called to heal and, in some circumstances, called to lead – and we have responded to the call. And this means that we have been listening for it, through prayer and through the influence and example of others. There are many examples of people heeding this call in both the Old and New Testaments (the prophets, Samuel, David, the disciples and, of course, indeed, Christ himself). As Christians called into the discipline of psychology, we are continuously watchful for that evolving call.

The second aspect concerns how we relate to others. As a Christian, one is continually challenged to be as Christlike as possible; to see the faith of Christ in others; and to let others see the face of Christ in you. There are, of course, parallels in many other of the world's religions. As mentioned above, we cannot, and are explicitly counselled against, wearing our faith beliefs on our sleeves. It would, I believe, be very wrong to do so. As psychologists we are reminded that we should treat others with unconditional positive regard, and so we do, but as psychologists who are Christians, we see our work as service, not just to the recipient, the service and, perhaps, the nation, but to Christ and to God.

And so, perhaps, we do not so much wear our faith on our sleeves but, rather, in terms of a resource. Thus, we wear it as armour, as in the hymn, St Patrick's breastplate, and in St Paul's letter to the Ephesians (Ephesians, 6, 17) where St Paul, in his letter to the Christians of Ephesus, talks about the shield of faith and the breastplate of righteousness (along with the sword of the spirit, the belt of truth and the shoes of the gospel of peace). Our Christianity not only encourages and supports our service but provides us with a pattern with which to execute the skills and knowledge gained during our training and post-qualification experience. In addition, vows to a religious Order, the Franciscans, in my case, place our daily life and work within a religious context, a scaffold or framework, as I like to think about it.

And so our Christian faith is a resource, as is our prayer life. But so is our membership of our church communities. I have always found the weekly Eucharist, or service of Holy Communion, to be particularly important. At the end of the service, the mass, we are sent out into the world to live and to work to Christ's praise and glory. And so we do.

But of course, the values that we hold as Christians often present us with challenges in our everyday work. And military psychology presents us with one such straightaway. My argument (the same that I used when I, myself, was a young officer in the British Army) is that one of the functions of the military is to endeavour to establish, or re-establish, world peace. Thus, when I was sitting in the cold mists of northern Germany with my armoured reconnaissance troop, I was doing my little bit to prevent a nuclear war, when in Northern Ireland, to help to keep the peace between Protestants and Republicans and so on. More day-to-day issues include maintaining patient confidentiality, and there are many others. Professional colleagues of other faiths, and none, are, naturally, presented with similar challenges as well.

And what of the role of Christian psychologists as leaders and managers? Here, I would argue, the situation is slightly different. Here, it is important, I would say, to be open about not only one's psychological health, discussed above, but also about one's faith and beliefs. It is not, for a moment, either pushing these down people's throats or foisting them upon them but just acknowledging that we hold them. Hopefully, if we are doing our jobs properly, these might become apparent – 'By their fruit shall ye know them'. Perhaps, even, this is an even more effective way of witnessing.

I have seen an ever-increasing increase over my career in the interface between psychology and spirituality. Some of this is explicitly Christian (e.g. the Network of

Christians in Psychology) and some much more generic, as with the burgeoning interest in the ancient Buddhist practice of mindfulness. As a Christian, I am almost certainly more interested in endeavours that are specifically Christian, but in an increasingly secular world, I am of the belief that any interest in spirituality is to be warmly welcomed.

What would I say to any young Christian contemplating a career in one of the many fields within psychology – academic, research and teaching, clinical, counselling, educational, forensic, health, neuropsychology, occupational, industrial and organisational and sports and exercise? I would ask them to embrace it with all their might as it offers, in my experience at least, one of the very best opportunities possible to have a career in which to express the values of a Christian faith.

I mentioned earlier on in this chapter that I began attending daily school chapel at the age of 8. This was where I first learned two prayers that have been my talismans ever since.

The first of that is of St Ignatius of Loyola, a soldier turned religious, and the founder of the Ignatian tradition, followed by the Society of Jesus and the Jesuits, among others. He wrote:

> Teach us, good lord, to serve thee as thou deservest; to give, and not to count the cost; to fight, and not to heed the wound; to toil and not to seek for rest; to labour, and not to seek for any reward, save that of knowing that we do thy will.

The second comes from another soldier turned religious, Saint Francis of Assisi. Although it is uncertain as to whether Francis himself actually wrote this, the following is attributed to him:

> Make me a channel of your peace. Where there is despair in life, let me bring hope; where there is darkness, only light, and where there's sadness, ever joy. Oh, Master, grant I may never seek so much to be consoled as to console; to be understood as to understand; to be loved as to love with all my soul.

As it happens, I too turned out to be a soldier turned religious, but my main calling has been to live out a Christian life as a psychologist, led by God, inspired by Christ, accompanied by the Holy Spirit and living in company with the saints, both dead and alive. And the journey continues.

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# Chapter 18
# Treating Christian Patients as a Non-Christian Psychiatrist


**Sharon Packer**

## Introduction

Certification in Orthodox Jewish Education seems like an unlikely credential for a psychiatrist who treats pious Christian patients from charismatic or separatist sects or from Catholic religious orders or world-renouncing religions. One might think that board certification in psychiatry would suffice, since that is the gold standard for medical specialists—yet standard psychiatric affiliations sometimes scare off persons who know of the anti-religion attitudes espoused by Freud and many of his followers and who fear that their religious values will be devalued or denounced as psychopathology. Those fears are not entirely unfounded since contemporary data confirms that psychiatrists overall—and not exclusively psychoanalytically inclined psychiatrists—are less likely to be "religion-friendly" than other medical specialists.

This grounding in Jewish observance has almost always helped me connect to patients who take their Christian faith seriously, even though our religious rites and beliefs are different. There is still an overarching point of commonality in our commitments to our creeds. In my experience, the outlooks of those whose lives were molded by religion differ dramatically from the persons who deem themselves "secular." It is difficult to explain the nature or depth of that commitment to those who never experienced it, as Freud himself admitted in his correspondence with Nobel Prize winner Romain Rolland.

Like myself, the lives of the patients whom I discuss in the vignettes below (but whose identities have been distorted enough to make them unidentifiable to others) have been shaped by their religion, and not just in terms of sectarian education or attendance at church or participation in prayer circles. For many, their everyday behaviors and thoughts are intertwined with religious rites and rituals, and with

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prayers or penance. Some such rites and rituals are readily observable—such as rosary beads or ashes on foreheads—but some committed Christians do not wear garb or jewelry that reveals their religion, and show no outward signs of inner beliefs that distinguish them from secular Americans who do not define themselves by religious affiliation.

As a psychiatrist, it is my job to identify those beliefs and practices and determine how they impact an individual's experience of the world and how they color perception of symptoms that prompted a psychiatric consultation, be those symptoms physical or strictly psychological. Psychological reactions to physical disease are just as important as the illness itself. It can be equally important to learn if and how those religious tenets connect them to a religious community—or disconnect them from more secular or less sectarian society. Sometimes the psychiatrist is called on to differentiate the delusional ideas related to neuropsychiatric illness from culturally accepted and normative religious belief systems. Moreover, persons with serious mental illness may espouse genuine religious ideas that exist apart from their psychotic ideas, and that shield the patient from completing suicide and offer other forms of psychological solace or social support. In some cases, consultation with practitioners who are familiar with a specific faith can be helpful, while in other cases, a psychiatrist who is not affiliated with the patient's religious faith is hyperalert to the ideas that differ from their own religious system, and so may identify the social impact of an individual's religion even more readily than others.

## Do Patients Choose Psychiatric Practitioners by Religion?

How a particular patient arrives at treatment may be as relevant as the reasons why they sought treatment. For instance, in the ER, we distinguish patients who arrive by ambulance from those who ambulate independently or those who are brought in by police or parents. In clinics and private practice settings, such "choices" may come about by chance or convenience, and some patients have no choice at all. Importantly, physicians who self-identify as "religious" are less willing than nonreligious physicians to refer their patients to psychiatrists, who are less likely to identify as "religious" and more likely to be Jewish than the general population or than the physician population at large [1]. Some physicians recommend clergy consultation over psychiatric appointments.

Some Christian patients preferentially seek out Christian-based counseling from the start, while others are sent to religiously affiliated psychiatrists chosen by their church and endorsed by their families. Some are discouraged from seeking psychiatric help. Some avoid medical care in general and are told to rely on faith and prayer alone. Mary Baker Eddy's Christian Science is perhaps best-known for this anti-medicine and anti-psychiatry attitude, but it is not the only group to preach against medical interventions.

Alternatively, others can access state-of-the-art treatment through the once large (but now shrinking) Catholic hospital system, which typically includes psychiatric

as well as substance use wards and clinics and is by no means restricted to Catholic patients. Other mainline Protestant denominations, such as Presbyterians, Lutherans, Methodists, and others, set up hospital systems, some of them very extensive, as have smaller religious communities, such as the Mennonites.

For persons who have fallen off the path, or who were shunned or excommunicated or de-fellowshipped by their churches, it is not surprising that they seek psychiatrists from outside their immediate circles, possibly out of anger or shame, or because they prefer to disassociate themselves from beliefs and practices that they dismissed—or that dismissed them. Those who are silently contemplating leaving religious orders may understandably avoid sharing their secret thoughts with designated "spiritual advisors," and so seek out "unbiased" outside opinions.

The dedicated Christians to whom I allude are diametrically different from the "nones" counted by Pew reports. Some previously religious people who leave their faiths also identify themselves as "nones," yet retain strong sentiments regarding the religions they left. "None" is a shorthand census term for those who check the box marked "none" when asked to choose a religious affiliation. The number of "nones" in America has been increasing steadily, with 40% of millennials born between 1981 and 1996 identifying as "none" [2–5].

Ironically, during the same decades when more Americans dissociated themselves from organized religion or professed belief in "spirituality" rather than in "religion" per se, charismatic Christian groups added more and more members. Their numbers exploded in the 1960s and 1970s, creating many subdivisions, extending far beyond the so-called Bible Belt, and attracting adherents from broader economic and geographic backgrounds.

Some enclaves in this country revolve around specific Christian religions, so one might think that only psychiatrists who practice in specific regions—such as the Bible Belt or Salt Lake City—need to be familiar with those local religions, but my experience proves otherwise. At times, committed members of religions (such as Mormons or Mennonites) that are centered in specific cities or counties move outside of their circumscribed territories. As my examples below show, it is not rare to encounter such pious Christian persons in major metro areas, although it is even more common to encounter previously pious persons who migrated to large cities that offer anonymity and tolerate a wider range of lifestyles, many of which are marginalized, if not outright verboten, in other regions. In spite of conflicts with their religions of origin, religion often permeates their consciousness—especially when "exiled" or excommunicated.

When treating those who lost their faith, or were forcibly removed from their communities, it is essential to examine the sense of loss or the feelings of being lost that come with being "cut off." Some compare the pain that follows to phantom limb pain experienced by persons who lost a limb, and who feel pangs of pain forever after, even when aware that their limb is missing.

Each religion is unique, and each individual who follows his or her faith follows it in his or her own way—or each doubts it in his or her own way, even when church elders or canon law designate official practices or official beliefs. Because there is such variability from community to community and from person to person, the best policy

is to "always ask, and never assume." In my experience, most patients welcome sincere questions, and are ready to "translate" insider terms that carry specific connotations within their faith tradition. By acknowledging that one was not reared with their specific beliefs or practices or educational systems or religious organizations—but also acknowledging that one is actively involved with another religion and that one appreciates the importance of religion in a person's life—one can elicit valuable information about the individual's experiences, and tailor treatment to the needs of that patient.

## How I Came to Treat Devout Christians

During my psychiatry residency at a large Catholic hospital in New York City's Greenwich Village, I expected to encounter two distinct (but not necessarily mutually exclusive) groups: the bohemian artists and counterculturists who colonized Greenwich Village, and practicing Catholics who were true to their faith yet were willing to accept psychiatric interventions.

Seeing religious artifacts on the walls and passing nuns in the hallways confirmed that Catholicism guided the lives of many staff and patients—even though one-third of the doctors were said to be Jewish, and even though the hospital served persons of any faith. Disaffected Catholics also surfaced with some regularity. Some psychiatrists were committed Catholics, ready to expound upon the nuances of their religion, and help me understand how they distinguished true spirituality from schizophrenic symptoms.

One such supervisor spent morning rounds discussing the voices that spoke to the prophets or the visions of beautified saints. He admitted that such persons would be deemed schizophrenic today, even though their stories are held sacred by believers, himself included. More secular psychiatrists might have used this same information to invalidate religious ideas altogether.

Another supervising psychiatrist was a former nun who lost faith in an order that devalued women. She retained interest in the ways that others reconciled seemingly irreconcilable aspects of their religions. The third supervisor was less involved with religion but was most influential, for he gave me his "blessing" to share some facets of my own religious background with a struggling patient who could not believe that anyone understood the intensity of his own religion.

Ordinarily, psychiatrists shy away from self-revelation, but, according to this supervisor, this disclosure could be helpful, rather than harmful, since so many patients believe that psychiatrists reflexively denounce religious ideas or dismiss faith as delusional and attempt to distance patients from faith communities. Such concerns are not unfounded, given that American Psychiatric Association (APA) surveys show that psychiatrists, of all medical specialists, are the least likely to practice a religion [1].

Rereading some early psychoanalytic texts is even more telling, especially Freud's book, *The Future of an Illusion* (1927), which compared religious rites to OCD (obsessive-compulsive disorder) rituals, and vice versa. For Freud, belief in a deity represented infantile dependency, and a lower level of psychological maturity.

Freud's last book, *Moses and Monotheism* (1939), written in his declining days, was even more damning, not just of religion in general but of his own religion.

Freud bragged that psychoanalysis had to be invented by a "G-dless Jew," meaning that this supposedly novel approach was iconoclastic enough to require the input of an outsider, such as a Jew [6]. Freud lived and worked in a largely Catholic Vienna (after having migrated with his family from a more traditional eastern enclave in Moravia). He perceived himself to be an outsider, even though historical data does not support his contention that he, as a Jewish doctor, was an aberration in Austria of that era. But merely being a Jew was not enough to challenge the reigning scientific orthodoxy. Being a nonbeliever, and an atheist, as he put it, who did not acknowledge a higher divine authority, was equally essential to his formulating his theories, or so said Freud. The weight that he accorded the sexual drives, and the way he linked humankind, the supposedly sacred culmination of the divine act of creation, to the lowlier animal kingdom, clearly contrasted with beliefs that saw humans on a continuum with the divine.

A successful analysis, according to Freudian thought and that of his followers who were often more orthodox than Freud himself, would "cure" analysands of their need to believe. In spite of his skepticism, Freud openly discussed religion with friends such as Romain Rolland, the Nobel Prize-winning novelist and mystic who described the "oceanic feeling" of universal connectedness. That sensation intrigued—yet eluded—Freud. Ironically, those who followed in Freud's footsteps often adhered to his teachings as devoutly as religious acolytes, so that some of Freud's detractors referred to him as "St. Sigmund" who founded the "Freudian Faith" [7]

Although Freudianism does not retain the prestige that it claimed in the mid-twentieth century, Freud's influence on culture, and especially on American culture, cannot be denied, even if many of his scientific contentions have been disputed over time, and supplanted by "evidence-based medicine." His influence persists enough, so Christians who fear rejection by "regular psychiatrists" can hardly be called delusional.

There is a darker side to this association between Jews and psychoanalysis (which many people conflate with general psychiatry, possibly because psychoanalysis has been so prominent in cinema) [8]. The Nazis called psychoanalysis the "Jewish science" and burned Freud's books at bonfires. Freud himself feared that his innovative ideas would be dismissed as a "Jewish national affair" because most members of his inner circle, save for Carl Jung, were Jewish. Yet even Freud never predicted that bans on his so-called Jewish science presaged the Nazis' genocidal plans.

## Vignettes About the Interface Between Christianity and Psychiatry

The following section is adapted from case histories of actual patients whose identifying information has been altered to conceal their identity while revealing the essence of their conflicts.

## Mormonism, Alcohol Abstention, and Social Interaction

Danny was a Mormon, straight from Salt Lake City. Danny's job saw him as a rising star and sent him to headquarters to connect with the powers that be and rise even higher in the real estate world. As a Mormon, Danny believed that his piety would bring him financial success and saw no conflict between material wealth and spiritual adherence, but he felt out of place with the hard-partying crowd at his job assignment in NYC. To be fair, he might have felt out of place with other Christian groups as well, considering that Mormonism is sometimes categorized as distinct from generic Christianity, and historians expect it to evolve into its own sub-religion.

While he did not belong to a world-disavowing religion and his faith did not advocate asceticism or poverty, he faced other restrictions. He did not drink coffee or tea or alcohol—but it was the alcohol restrictions that created the job problems and the "write-ups" that in turn led to anxiety and insomnia and psychiatric consultation. He was distressed when his supervisor gave him an uncharacteristically bad review after coworkers complained that he was not a "team player."

So, Danny was sent to EAP (Employee Assistance Program), where the EAP social worker refers clients to psychiatrists and tries to find the "right match." In talking to Danny about his past successes, and his lack of prior psychiatric problems, and the circumstances that led to his referral, it struck me that his refusal to go out drinking with his coworkers, and his inability to cement relationships at the local watering holes, and "good behavior" that put coworkers on the defensive, prompted complaints about not being a "team player." As per the recommendations of my residency supervisor, I consoled Danny, reminding him that I, too, would be at loss if my coworkers insisted that I join them for barbeque spareribs (an obviously unkosher choice). Danny accepted the analogy. As a Mormon, Danny was well-versed in Jewish practices, and knew that his church parallels founder Joseph Smith's exile to the Israelites' exodus.

When EAP conveyed my psychiatric assessment to his supervisors, they recanted, but Danny already decided that he was far more comfortable with his coreligionists in Salt Lake City. He had no interest in mirroring city lifestyles and hitting the downtown bars with teammates—a "solution" that might have been taken by someone with fewer religious convictions than Danny.

Michael's experiences with Mormonism did not end so well. He embarked on a year of missionary work, expecting to continue his post-high school studies at Brigham Young University, then marry, and start a family. But exposure to the wider world while missionizing made Michael rethink his sexual orientation. His colleague reported him, and when he returned to SLC, a tribunal of sorts awaited him and officially excommunicated him. Left alone without his customary social support and without his spiritual foundation, he sought refuge in a different form of "spirits." He eventually made his way to Reiss 4, the hospital's alcohol detox ward.

Michael was reluctant to join Alcoholics Anonymous (AA), because of its religious connotations, but he met a Catholic-born man who had converted to the

Episcopalian Church because the latter was more accepting of varied lifestyles. He followed suit. Unfortunately, this more liberal church did not provide the cohesive community and external structure to which Michael was accustomed. The last I heard, Michael returned to Reiss 4 every so often, never achieving a full recovery from alcohol and never recovering the sense of self that he lost after his excommunication.

## Mennonite Communitarianism

Natalie's situation shared some similarities with Danny's. Her religion retreated from the world, except for missionary work. She was born into a liberal branch of the Mennonite church (a subdivision of the Anabaptists). Her church did not demand specific dress codes, save for basics related to modesty, so her religious affiliation and commitment were not obvious to those who did not know her. I, as her psychiatrist, knew about her background from the get-go, for I ask about religious affiliation (and other cultural questions and language preferences) on the initial intake form, which is completed in advance.

In contrast to Danny, Natalie's colleagues never complained about her refusal to be a "team player." Just the opposite occurred. A recently minted physician, she came to town for an infectious disease fellowship, to prepare her for medical missionary work in Africa or Asia. She had recently returned from Louisiana, where she studied at Tulane's tropical disease clinic and at America's last remaining leprosarium (which closed in 1999). In New York City, an epicenter of the AIDS epidemic, she would learn about the disease that also ravaged the developing world.

No one objected to her behavior at work because she did not object to anyone's demands—she agreed to cover every weekend, holiday, every overnight shift that her colleagues imposed on her. Understandably, she became fatigued and then depressed because she was so overworked.

Natalie never said no because it was not the neighborly thing to do, or at least that was the way it was in her Mennonite faith, where the community is valued above the individual and everyone helps one another in service to Christ. She did not understand why others refused her requests to cover day shifts that let her rest up after long nights on call. It took some effort to explain that most New Yorkers are not as neighborly or as charitable as she, even though, as doctors, they did good works for their patients. Without undermining her religious values, and while expressing admiration for her communal concerns, I pointed out that her coworkers had different value systems and that she needed to say no when confronted with unreasonable requests. The extra rest that resulted from fewer hospital shifts, along with a 6-month course of antidepressants, helped override her depressive symptoms. With fewer shifts, she could also return home to her Mennonite community over holidays and some weekends.

## Pentecostalism and Apostolic Faith Healing

Emanuel was born into a Pentecostal family in a region that he described as "backwoods Tennessee." He unexpectedly made a minor name for himself in Outsider Art circles, when a gallery owner came to his rural mountain town in search of raw art by self-taught artists. Art infused with religious inspiration was especially valued. Compared to the meager living eked out by his ancestors, Emanuel received what could rightfully be called a "windfall."

He came to town to attend the annual Outsider Art fair and meet "city people" who collected his wood carvings, but he was unimpressed by the city and remained committed to his faith. He sorely missed his family. He had never seen a psychiatrist before and almost never visited medical doctors because of his family's religious beliefs. He even received a religious exemption from school vaccines, long before the "anti-vax" movement gained traction.

As he explained, his religion grew out of apostolic Christianity, which evolved in the first millennium when faith healing and belief in miracles were commonplace. His family and fellow parishioners took great pride in tracing their roots back so far in time, even though the American charismatic movement did not emerge until the early twentieth century, before exploding in the 1960s.

Emanuel might not have given much thought to his religious background had it not come into conflict with the emergency treatment he needed. His depression grew to such intensity that he begrudgingly sought out therapy at the recommendation of his gallery owner. He consulted a social worker therapist, which was not so out of line with his values. By the time she referred him to me, his moods changed unpredictably. He was laughing one minute and sobbing minutes later. Then the paranoia started, and he perceived that people were following him. It was not until he felt suicidal and was at risk for involuntary hospital admission that he agreed to start psychotropic treatment. Still, the question was: which treatment should he receive?

His rapidly shifting psychiatric symptoms were atypical, and some symptoms sounded more like pseudobulbar palsy than straightforward bipolar or schizoaffective disorder. Still, he noted that some relatives heard voices and saw visions, suggesting a familial tendency toward psychosis, even though their church deemed them to be the "chosen ones" with spiritual gifts.

His condition took a different turn when he developed optical neuritis, which landed him in a medical ward. The neurological workup and MRI that followed put MS (multiple sclerosis) high on the differential diagnosis. Suicidality and psychosis were no longer his only problems. After running additional laboratory tests, and reviewing his clinical history, the neurologist discussed treatment options to abate his acute symptoms and postpone progression of a potentially devastating disorder.

It was a scary time indeed, and Emanuel was inclined to consent to medical treatment, but his family denounced it and demanded that he rely upon prayer alone and return home. The family conflicts that followed tormented him as much as his psychiatric symptoms.

Although he had just turned 18 and was legally able to make independent decisions, Emanuel's situation recollected controversies related to Jehovah's Witnesses

who refuse lifesaving blood transfusions for their children. It also reminded me of Anne Fadiman's best-selling book, *When the Spirit Catches You and You Fall Down* [9]. She told the story of a Hmong child whose refugee parents refused American medical treatment because they believed his seizure was a sign of the divine and not a symptom of disease. After a lengthy legal battle between the parents and the hospital system, the child survived the ordeal, but emerged brain damaged, never to talk again. The book blamed the parents' resistance to medical recommendations on the doctors' refusal to recognize their religious concerns.

That tragedy did not happen here because we discussed Emanuel's religious beliefs from the start, long before reviewing possible consequences of untreated multiple sclerosis—and the relative successes of averting serious complications such as paralysis and vision loss. All the while, we reinforced the importance of his religion and left it to him to prioritize. When he was perplexed by the link between MS, brain disease, and mood and perceptual symptoms, I showed him photos of his MRI and identified brain lesions that potentially produced psychiatric, as well as neurological, symptoms. As an artist, he could grasp explanations when illustrated with the MRI, but he was still between the proverbial rock and a hard place, intelligent enough to understand the potential consequences of his condition, yet emotionally connected enough to both family and faith to feel conflicted. Eventually he decided to accept medical treatment, and to remain in New York longer than planned, where such treatment was more accessible than in rural Tennessee. He chose to avoid discussing this decision with his relatives altogether.

## Burned-Over Districts, Glossolalia, and Seizure Disorders

Charles' story is the saddest, but perhaps the most significant example of the interface between psychiatry, Christianity, and even neurology and general medicine. Charles was born in the so-called Burned-Over District of western New York state, where revivalism recurred so regularly that a prominent early nineteenth-century evangelist renamed the region. To Charles Grandison Finney, the district was so (metaphorically) consumed by spiritual fire that it appeared to be "burned over" [10–12]. It was there that the Second Great Awakening began and never completely ended.

Charles' story was convoluted. While still in high school, he visited NYC for a school trip. We later learned that he had surreptitiously experimented with religiously prohibited same-sex behavior while in Greenwich Village, stealthily avoiding the watchful eyes of chaperones.

After returning home—where ecstatic religion was the norm rather than the exception—seizures began. His family and fellow parishioners saw the "fits" as sacred, and not as manifestations of medical pathology. To church elders, his incoherent utterances were "speaking in tongues." Glossolalia was proof that he had a special calling. At the NYC clinic, he also described classic signs of postepileptic mania, with intense affect, racing thoughts, and flight of ideas.

This tale reminded me of Hippocrates' contention that epileptiform disorders were medical concerns and not visitations by divine spirits, in spite of prevailing beliefs to the contrary. Until either Hippocrates or his followers wrote *On the Sacred Disease*, even the relatively rational Greeks linked epilepsy to prophecy, as did many ancient and some contemporary peoples. However, the Hebrews distinguished potion-induced seizures from spontaneous seizures and deemed drug-induced visions as invalid [13].

Sadly, Charles' situation was more than a curious footnote to the history of medicine. His NYC visits took place at the start of the AIDS epidemic, and he likely was infected through that anonymous encounter. The seizures were the initial manifestation of an even more deadly complication of HIV infection, an opportunistic infection in the CNS (central nervous system).

So, on his next visit to NYC, he consulted the clinic, which sent a nondescriptive letter to the address he listed, reminding him of his follow-up appointment. His parents intercepted the letter. Already suspicious, since they previously commented on his "gender-inappropriate" interests, they apparently read between the lines, but never said a word. Instead, according to Charles, they positioned Bibles in every room, conveniently opened to pages that demanded death penalties for persons who indulged in same-sex relations.

Ousted from his family home, Charles arrived in NYC alone, disembarking at the infamous Minnesota Strip near the Port Authority bus terminal, where Catholic charity workers were on the lookout for vulnerable unaccompanied youth. They brought him to the hospital ER, where the doctor heard his story and ordered an emergency psychiatry evaluation and infectious disease consultation. Charles also received a referral to a religious hostel for homeless youths, but his stay at the shelter would be cut short when his opportunistic AIDS infection progressed.

With treatment options so limited at the time, Charles' condition ravaged both the body and brain. When he could piece words together into sentences, he insisted that no one could understand how prayers permeated every aspect of his life. At my supervisor's suggestion, I assured Charles that my religion also required the recitation of specific prayers before every meal or upon smelling fragrant flowers or hearing the thunderstorms or seeing lightning flashes. We also said special prayers for the sick. Such prayers did not save Charles.

Charles faded away a few days later, showing no signs of either depression or anxiety. In the end, I wonder if his passive acceptance of his fate was more than just a manifestation of the apathy that can accompany organic brain disease. Perhaps it also signaled his belief that he did indeed deserve the death penalty for breaching Biblical taboos that he still held sacred.

## Jehovah's Witness and the Apocalypse

Marie was born a Witness. Both parents were Witnesses who descended from nineteenth-century Millerites. She had not been recruited into a "cult" although some critics have claimed that Witness recruitment involves techniques that could be called cultlike. Marie would have remained a Witness had she not been de-fellowshipped for violating marriage vows and getting pregnant with another man's child.

Although she miscarried before her pregnancy became physically apparent, her religious community became aware of this event when her husband petitioned for divorce. She was publicly excoriated and officially de-fellowshipped. In contrast to Hester Primm, who was forced to wear a scarlet letter while remaining within the confines of her community, Marie was forbidden further contact with active Witnesses (including members of her immediate family).

Theoretically, she could maintain contact with "worldly" people who were not Witnesses or those who were similarly de-fellowshipped, as happened with some distant cousins, but she was too distraught and ashamed to reach out to them. She was essentially sent into exile, recollecting the rabbinical Judaic punishment of "charem," where the miscreant is banished and restricted from communication with coreligionists. (More severe sins in Judaism merit "careth," whereby the sinner is literally cut off from the collective soul of the Children of Israel in life and death.)

To me, such humiliation sounded harsh, but to Marie, it was to be expected. She was neither angry nor hostile but simply accepting. However, she developed a depression in response to increased social isolation during COVID lockdowns. Surprisingly, she had been able to function well until then, rising through the ranks at the NY Stock Exchange, which did not demand a college degree and promoted on merit alone, indifferent that she lacked post-high school education because her church discouraged secular college education.

When COVID closed her workplace, cutting her off from all communities and leaving her alone with her thoughts, her preoccupation with the impending apocalypse prophesized by her church peaked. She wanted medication to stop these frightening thoughts. Marie was also between a rock and a hard place, because she might escape the foretold apocalypse, should she repent. However, she could not repent and return to the fold because she had been de-fellowshipped. This dilemma exceeded the capabilities of most medications that I prescribed.

Even psychotherapeutic interventions did not suffice. Cognitive behavioral techniques that combat catastrophizing could not overpower her strongly held religious beliefs. Finally, at my suggestion, Marie sought out other de-fellowshipped Witnesses to ask how they coped with such dilemmas. While googling for information, she came across far more former Witnesses than she ever expected. She also sought out her "worldly" cousins, who confessed that they were not as convinced of the impending apocalypse as they once were. It was difficult to witness Marie's struggles, but it was reassuring that she was reconnecting with relatives who traipsed through similar terrain. There was no simple solution to her situation, but it was better that relatives, rather than I, broach those religious tenets.

## Catholicism and Abortion

Anthony was a "casual" Catholic who had attended Catholic school but was never much of a churchgoer. After 20 years on the police force, he retired, working security, doing extra night shifts to cover alimony payments. He insisted that his drinking did not detract from his work but admitted it destroyed two marriages. When his

blood pressure increased after he left the force, and he could no longer attribute his hypertension to job pressures, he came clean about his drinking—and just in time, because his doctor showed him his lab tests with elevated liver functions. At her urging, he started AA and refound religion of sorts, plus the camaraderie that he had enjoyed on the force. Yet he did not find full sobriety and so he sought out a psychiatrist.

With extra help from naltrexone prescriptions and supportive psychotherapy, he got sober—but did not find peace. Working the security desk offered too much time to reflect on the past, thinking about the "love of his life," the teenager who agreed to terminate an unplanned pregnancy at his request. Yet she left him soon after, leaving him to marry his second choice. His AA sponsor suggested that he start the fourth step, do a thorough personal inventory, and make amends to anyone he had hurt, provided that doing so would not cause them further hurt. At that point, he came to the realization that his first girlfriend probably never forgave him for pressuring her into the abortion, and perhaps he never forgave himself either.

Some psychiatrists might have assuaged his remorse with scientific data and political polemics that devalued the Catholic antiabortion stance, but I recommended that he contact his old priest, attend confession, and disclose the details. He seemed surprised to hear that recommendation from a psychiatrist whom he knew was Jewish and did not expect to share his ambivalent attitudes toward abortion, but I suspect that he took my suggestion more seriously as a result.

I assured him that the Church had become more accepting since he was a youth in Catholic school, even if it had not changed its stance on abortion. It was clear to me that absolution from the priest was more important than appeasement by a psychiatrist. To his surprise, the priest recommended only minor penance, specifying acts of charity, along with prayers—but advised against contacting his old girlfriend because reminding her of an unpleasant event from the past could hurt more than help. Interestingly, historians of psychiatry have compared the Catholic confessional to psychoanalysis' talking cure. Some suggested that Freud coined such techniques in Catholic Vienna because his nanny took him to her confession [14].

## Summary

The cases highlighted represent relative successes, rather than failures. But, truth be told, I have encountered next-to-no obstacles when treating Christians of faith and meeting them on their own terms. My darkest memory concerns a representative of a Catholic charity who commended me on my treatment, exclaiming that he was so happy that his referral did not lead to "one of those Jewish psychiatrists." To be kind, perhaps he meant that I was not one of the "atheist Jewish psychiatrists" (as Freud described himself) but perhaps not. Either way, he was one person out of thousands, and he deserves the benefit of the doubt. When speaking of religion, surely forgiveness is in order.

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# Chapter 19
# A Jewish Psychiatrist's Perspective

**H. Steven Moffic**

> Who controls the past controls the present: who controls the present controls the future.—George Orwell, the novel 1984

As most any psychiatrist who thinks that the past influences the present and future, my perspective on Christianity and psychiatry goes back at least to my conception. Although I didn't realize this until much later in my life, when I discussed a movie titled "Hitler's Children," in the broadest sense, I was one of Hitler's children, if not a child of the Holocaust. No, my Jewish parents were not survivors, but they only met because my father was stationed in Dayton, Ohio, before the end of the war where he met my mother, and I was conceived not too long afterward. As far as my parents' parents, they apparently came to the United States from different parts of Romania, a Christian country, as I found out from a trip there a few years back. Unfortunately, it appears that the rest of our families were killed there in the Holocaust. That late history and revelation has inspired me to advocate whenever possible for "Never Again" as far as a Holocaust or any genocide goes (Fig. 19.1).

## Growing Up

After spending the first years of my life in an integrating neighborhood near the University of Chicago, we moved from South Chicago to the northern part. Actually, much later during my psychiatric residency at the University of Chicago, I was doing a student mental health rotation as part of my residency training in the same apartment building in which I grew up in until I was 6 years old! Perhaps that was just a coincidence, but it seemed to tie together my early childhood with early adulthood and mental health.

After moving, I grew up mainly in a 12-square middle-class block area, all Jewish, in Chicago. Therefore, I went to an all-Jewish elementary school and had all Jewish friends until high school. I was expected by my mother to be a doctor or lawyer,

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**Fig. 19.1** Synchronicity surrounds us. Digital image by Barry Marcus

common for the hope of American Jewish mothers for their sons at that time. I went to a conservative Jewish synagogue with my family and had a bar mitzvah at the age of 13, but all that just felt like something I had to do and not essential to who I was. I was even kicked out of Hebrew school along the way. At the time, I didn't feel religious or spiritual at all. I could probably be characterized as an agnostic student/athlete.

Come high school, I had to venture out of that safe and monochromatic neighborhood. The high school was mixed with Jews and Christians. But it turned out to be nothing like the movie and play *West Side Story* that came out at around the same time. We really did all get along. Nothing much was said to me about the difference of being Jewish, though I mainly had Jewish friends. However, my mother repeatedly told me that I had to marry a Jewish girl. OK. That didn't seem to matter in my sports world where there were no girls anyways other than cheerleaders. I continued to dream that I might be a professional baseball player, even though not many Jews did so. I found out in high school that Sandy Koufax was Jewish and a star

left-handed pitcher, and I was also left-handed and a pitcher. My favorite players on the Chicago White Sox were Minnie Minoso, a Black Cuban-American, and Luis Aparicio from Venezuela. My dream, though, was shattered by breaking a leg skiing.

This was also a time when many Jews changed their last name to assimilate more into American society and be less identifiable. An example was Lenny Bruce (1925–1966), the stand-up comedian, social critic, and satirist, whose birth name was Leonard Alfred Schneider, but who felt that it had to change for "show business." Nevertheless, he riffed on the cultural essence of Jewish and Goyish (not Jewish) in this brief excerpt from his famous "shtick" (meaning comic piece in Yiddish), Jewish and Goyish:

If you live in New York or any other big city you are Jewish. It doesn't matter even if you're Catholic; if you live in New York, you're Jewish. If you live in Butte Montana, you're going to be goyish even if you're Jewish.

Perhaps Bruce was prophetic, for in April 2020, anti-Semitic flyers were found on vehicles in Butte, Montana, another example of the rising anti-Semitism in the United States in recent years. This time, though, the rise seems to be coming from not only the Christian "alt-right" but the more extreme political left.

Then there was music. Rock 'n' roll was emerging, and it became clear that its roots were in Black-American rhythm 'n' blues. That led me to my favorite music, jazz. Jazz was America's original music, and it developed out of blues and gospel, Christian gospel music, but animated by Black culture. Jazz connected with other cultures in the world, and Stan Getz, who was Jewish, had a famous connection to Brazil in his hit song "The Girl from Ipanema." Benny Goodman, who was Jewish, was a star of the Swing Era of the 1930s. I heard, too, that music was a healing force in the universe, so I thought, "well, if I don't become a doctor, I could be a jazz disc jockey." Interestingly enough, there could be a connection between my family's coming to the United States from Romania, and jazz. My paternal grandfather came first in 1898, alone, to escape army conscription. However, well before that, when the enslavement of Romania's Gypsies ended in 1864, tens of thousands led and several thousands settled in Black areas of southern states. So, when the oldest member of the gypsy band Fanfare Ciocarlia was asked once about the influence of jazz on the group, he supposedly answered: "Who's to say our cousins who went to the US didn't help invent jazz?"

In high school, the third influential intersection was reading Freud's *The Interpretation of Dreams*, and I ended up also dreaming of becoming a psychiatrist. I knew that Freud was Jewish, but so what? Maybe I fit the stereotype of being a Jewish doctor afraid of blood. I came to find out that many of Freud's colleagues were Jewish, and that Jews were even more prominent in the development of psychiatry than in the rest of medicine. As I mentioned above, my mother wanted me to be a doctor, as many Jewish mothers of the time did, so I fulfilled that dream of hers.

So, when I entered the University of Michigan, my heroes were multicultural and multi-faith stars in sports, music, and psychiatry. Most importantly, I met my wife and muse there, and she passed the test of being Jewish, necessary for my mother. She was solidly Jewish in her identity and practice. I had joined an all-Jewish fraternity, but, once again, I ignored why I wasn't invited to – or interested in – the others.

I think that was superficial nonchalance rather than anything deeper in my unconscious.

## Medical School and Residency

I did well enough to get into Yale Medical School after 3 years without a major or degree. What a change that was from only decades before when there was a quota for Jewish admissions. There, the presence of Christianity seems to have had more impact on me. The medical school was culturally surrounded by a neighborhood of impoverished Black-Americans, though the school was decidedly WASPish (White Anglo-Saxon Protestants). I tried to learn how to fit into that WASP culture of being more formal and cerebral, though I felt most at home going to jazz concerts and working in the poorer area. To this day, I still didn't know enough about other Christian denominations.

I did start to pay attention to the conception of the United States as having Judeo-Christian values. That implied that Jews and Christians were strongly connected, even if Jews were a distinct minority numbers wise. Yet, I wasn't quite sure what those overlapping values in common were. Actually, I'm still not quite sure, though I have found out that the term became popular with the twentieth-century English essayist and moralist George Orwell in an attempt to fight anti-Semitism in the late 1930s. It was meant to indicate tolerance and solidarity with the persecuted Jewish religion of the time.

From 1972 to 1975, I did my psychiatric residency at the University of Chicago, again embedded in a poor Black-American community. My favorite rotation was in community psychiatry in that neighborhood. I also found out that working in such a setting would fit the Jewish value of Tikkun Olam, trying to heal the world. This experience served as a reaffirmation that community psychiatry was my career goal.

## Career Choice

I owed the army 2 years and came to be stationed on a base in Anniston, Alabama. The first question people asked us in the town was: "what Church do you belong to"? It didn't seem anti-Semitic, just a friendly attempt to connect. At worse, it was a hope we would convert and be saved. When I said that I was Jewish and went to a synagogue, I still felt welcome. Racism was there and more out in the open than in Chicago. At the public community mental health center, the head of children's services was a Black-American male.

Perhaps these Christian influences had something to do with how we celebrated Hanukah and Christmas back then. The idea to play Santa for our young daughter was not mine. Though I didn't think about this at the time, I would think that being a psychiatrist at that time of downplaying religion would have led me in the other

direction. If I was part of the predominant atheist culture of psychiatrists, would I not have scoffed at such a religious activity? Freud was still a major influence on psychiatry and viewed religion as being an opiate for the people at best, and a neurotic belief at worst. Nevertheless, he still felt Jewish in an ethnic sense. Since his time, there has been a humanistic denomination of Judaism that does not believe in a God.

However, my wife wanted me to play Santa Claus and I wanted to please her. That was more important to me than any religious beliefs I had or didn't have at the time. Moreover, it seemed like fun and I was just getting interested in masks, so I put on the mask and clothes of Santa. It worked, at least in its illusion and enjoyment of our daughter, who perhaps was already primed by attending Moody Bible preschool in Chicago due to the absence of other alternatives. She believed in Jesus then, and maybe still does a little. We later did this with our son, who was 8 years younger. By then, our daughter knew of the deception, so this time it wasn't the same.

In considering the outcome of these experiences on their development, is it possible that this could connect in any way to this same daughter now being a Sunday school teacher for many years at a Jewish synagogue? And, even more of a possible stretch, even connect to her younger brother becoming a Reform Rabbi and who also married a Rabbi? And, yet, he has written most of his books for a Christian publisher, including a book on the Jewishness of Jesus [1]. God, if one believes in a God, indeed may work in mysterious ways, as the saying goes.

Compare my experience with that of another Jewish psychiatrist colleague and friend, who became a secular Jew, but didn't want to continue the Christmas celebration he had as a child. He went on to tell me this about a decade ago:

When our older son was married it was an interfaith wedding. Our daughter-in-law wanted both faiths represented, but of course marrying outside of the faith is against Jewish law. With guidance from a learned friend I offered to co-officiate, and to my surprise they accepted. Meeting with our daughter-in-law's godfather, a retired Episcopal minister, to put the ceremony together, was a memorable experience. Without discussing it explicitly, we made a 'theological trade'. He edited out reference to the Trinity out of the book of common prayer ceremony. I edited out references to the chosen people. A reformed rabbi friend loaned me his handbook. A prayer over the chuppah referred to it as 'the ancient symbol of the Jewish home'. I changed the word order to 'the ancient Jewish symbol of the home'. I was just discussing Hanukah with our daughter-in-law (they celebrate it and Christmas). Our 17 year old grandson, a lovely and gentle young man, is a 17 year old atheist. He calls all religions 'hogwash'.

By the time I was to choose my first job, I felt connected and knowledgeable about various cultures. I took a job leading a large community mental health center in Houston in a contract with Baylor College of Medicine. Houston, at that time, had large Black, Hispanic, and Vietnamese populations. Fortunately, we also had an anthropologist in our Department of Psychiatry. My co-leader was a Christian Black-American woman social worker, who I also came to admire and learn from. We had a multi-faith and multicultural staff and celebrated all the winter cultural

holidays: Christmas, Hanukah, and Kwanzaa. I went to some Christian church services when invited by other staff. For those reasons and others, we were the first community mental health center to be featured in a new publication called Community Mental Health Center Spotlight.

Nevertheless, since Baylor itself was connected to the Christian-oriented (at least in name) Baylor University, I wasn't sure how much to reveal of my Jewish identity. My name and appearance did not seem stereotypically Jewish. I only sensed anti-Semitism when Jewish physicians were not allowed to go to lucrative teaching experiences in Saudi Arabia and nothing was offered to offset that.

## Scholarly Work

I was asked to teach the first-ever classes on cultural psychiatry by the residency director, James Lomax. In one of the first years of doing so, there was a Black-American resident, and together we decided to develop a model curriculum on cultural psychiatry and we did, publishing it in the late 1980s [2]. The key to the training was self-disclosure and discussion of our own cultural and religious backgrounds. Besides ethnicity and racism, religion became a focus, as it was becoming increasingly in general psychiatry. Actually, it wasn't easy for me to come up with how to define myself culturally: Jewish American, American Jew, Jewish, and American? Where would I want to be if somehow someday the United States and Israel came into deadly conflict?

My professional home in which to learn more was the Society for the Study of Psychiatry and Culture (SSPC). In the 1980s, I regularly attended their annual meetings and regularly presented on my concept of psychiatric education on cultural aspects of psychiatry. Perhaps coming full circle, as I write this second draft, I was just asked if I would consider being nominated for the 2021 SSPC Creative Achievement Award. Such connections in present time and/or with past time in recent years have led me to become more familiar with the Carl Jung's (1875–1961) concept of synchronicity, referring to those moments when everything metaphysically seems to come together, in the surprising juxtapositions that science can't seem to adequately explain [3]. In some ways, this preoccupation with synchronicity goes back to another formative book in my overlapping religious and psychological interests which I read after starting to peruse Freud, that by the psychologist and physician, William James (1842–1910), who focused on the various ways that people feel they have experienced the divine or spiritual [4].

One of the leaders of that society edited one of the early texts on religion and psychiatry [5]. Soon after this book, another SSPC colleague wrote a psychological interpretation of the Old (Jewish) Testament and the New (Christian) Testament [6]. This came out around the same time as my wife and I started to go to weekly Torah (Old Testament) study at our synagogue. Fascinating was the different levels of interpretation of the Torah text, similar to our interpretations of the psychodynamics of patients. The key leaders and their families in the Torah portrayed the same

wishes, desires, and conflicts as people and patients still do: the sibling rivalry of Jacob and Esau as well as Leah and Rachel; the narcissism of Joseph and his help in interpreting his dreams; and the leadership challenges of Moses, among them.

Another important professional organization was the American Association for Social Psychiatry, for which I became President around the turn of the new millennium. My role model in that organization was E. Mansell Pattison, M.D., who was also a Christian minister. In the 1985 annual meeting of the American Psychiatric Association, he opened with a prayer for psychiatrists [7]. We prayed for ecological, political, clinical, existential, and professional spirituality. Even since then, it has been my prayer of choice in the morning before work. Along the way, I received the onetime designation of being a Hero of Public Psychiatry from the American Psychiatric Association in 2002, largely due to my cross-cultural work.

Around the turn of the new millennium, my son decided to become a Rabbi, which inspired me to learn more about my own religion and culture. I finally learned about such Biblical heroes as Abraham, Jacob, Moses, and the Joseph who I joked was the first psychiatrist for his dream interpretation skills.

By that time, we had moved to the Medical College of Wisconsin in Milwaukee. There, I discovered a different multi-faith, multicultural society. It is said that in some parts of the city, every block had a church and a bar. Instead of the cowboy culture of Houston, it was Germanic. There were not only large populations of Black-Americans and Hispanic-Americans but Hmong, Serbian, and Somali refugees of various religious and spiritual backgrounds whom I tried to help by applying for state and federal grants. There was also a reasonably sized population of Native Americans, about which I learned much from the psychiatrist Carl Hammerschlag, who was based in Arizona. It seems to me that they are the most discriminated against cultural and religious group in the United States, and most deserving, if any group is, of reparations.

In the early 1990s, I was also asked to become Medical Director at a failing private hospital, St. Mary's Hill, under the School Sisters of St. Francis. I was asked to start my first meeting with a prayer. A prayer? I had never done that professionally before. It was then and there that I made sure everyone knew I was Jewish and fell back on the prayer of Dr. Pattison.

Eventually, I was involved in multi-faith symposia at the annual APA meeting. These were generally set up by the Hindu psychiatrist, Rao Gogineni. Subjects included forgiveness, death and dying, and eventually Islamophobia. I learned from the other psychiatrists and audiences. After the Islamophobia symposia, I was asked by an editor of Springer publishing company if I wanted to work on a book. When I asked if she was thinking of Islamophobia and she said yes, I asked why she was asking a Jewish psychiatrist to do that. I said that would not be politically correct in the very least. She said that she knew I had edited prior books and had some expertise in cultural psychiatry, and therefore would be likely to get it done. When afterward I talked with Dr. Peteet, a symposia participant of Christian religious belief, he was interested, too, so I told the Springer rep that if we could obtain Muslim psychiatrist co-editors, we would try. And we did, though along the way there was the challenge of whether this should be led by Muslims. However, I remained the lead

editor since no Muslim psychiatrist wanted to take over that role. Our two Muslim co-editors were Dr. Ahmed Hankir, a young Muslim male psychiatrist from Maudsley in Great Britain, and Dr. Rania Awaad, a young Muslim woman psychiatrist from Stanford, along with a multi-faith group of chapter writers, most of whom were Muslim [8].

It worked well and received good reviews in the professional [9] and lay press [10]. This is despite some differences of opinion along the way, such as whether to include a chapter on homosexuality, which I ended up writing [11]. We learned how Muslim physicians in the early middle ages set up the first psychiatric hospitals in Baghdad and had therapeutic concepts akin to cognitive-behavioral psychotherapy and Freudian psychodynamics, which were lost in history thereafter. We learned how important it was to incorporate Islamic beliefs in psychotherapy with Muslim patients. We ended up feeling and hope that our group was a model of sorts for a multi-faith society.

Success of the book, the first of its kind (titled *Islamophobia and Psychiatry: Recognition, Prevention, and Treatment*), was enough that we were asked to do a sequel on anti-Semitism and psychiatry [12], which was published at the end of February 2020, and received rave reviews in the professional [13] and lay [14] press. Despite trying, we couldn't find a chapter writer who was atheist for either of these two books. Interestingly, we didn't even think of trying to add a Mormon psychiatrist. That then led to a proposal to do a third volume in a trilogy, this one on Christianity and psychiatry, with the lead editor now being taken over from me by Dr. Peteet. In the anti-Semitism book, we presented new ideas on how the current rise of anti-Semitism might be reduced and found out some new information, including that Hindus have apparently never been anti-Semitic.

Nevertheless, the challenge remains to have the religions be more complementary rather than in conflict. History, starting with Jesus, almost suggests an unresolved Oedipal conflict at the religious level, that is, between the father, son, and then grandson, in terms of the development of Judaism, Christianity, and Islam.

## Administrative Work

Over the years I led many systems of care, with staff and patients of various cultural and religious backgrounds. Perhaps that has something to do with being awarded the Administrative Psychiatry Award by the APA in 2016. In my acceptance lecture, I emphasized the importance of loving your staff. This kind of compassionate and caring love, I was told, was similar to the Christian theme of agape. Agape is a Greco-Christian term referring to a kind of universal love that seeks the best for others. I tried to love each staff member and do the best I could for their personal development, which in turn should enhance patient care. Here I can see an overlap of the Jewish value of Tikkun Olam, to heal the world, with the Christian agape love.

## Clinical Work

Now, clinically speaking, besides such scholarly endeavors, I always asked about religious and cultural backgrounds, and strove for the cultural sensitivity and humility that undergird cultural competence. I was asked to work part-time at both Jewish Family Service and Lutheran Child and Family Service. Christian Family Solutions is part of the Lutheran organization and currently specializes in services to youth, including an intensive outpatient day therapy program called STRONG (Successfully Treating and Reaching Our Next Generation).

Probably most important was that I added a spiritually oriented question when the scheduled times for medication visits decreased at my institution. When it got down to 15 minutes, I wondered how to make best use of this time. Just ask about side effects? How would that affect the therapeutic alliance which was always so important to me and the outcome for patients?

Who came to mind was not Freud, but Viktor Frankl, M.D., the Jewish psychiatrist who came out of the concentration camps to write the perennial best seller, *Man's Search for Meaning*. Actually, Frankl knew Freud, who helped him out as a psychiatrist in Vienna. Frankl reported that finding meaning, especially in thinking about love relationships, is what kept people from not giving up, even in a concentration camp. He ended up founding a school of psychotherapy called logotherapy, a kind of existential psychotherapy.

What I did, then, is to add a question for all patients, either to be filled out in the waiting room or asked at the beginning of the session: what gives your life the most meaning? With the answer, I tried to gear the medication to whatever seemed to be valued. And it seemed to work, making the brief sessions seem more meaningful to the patients and myself. I was also invited to discuss this with family meetings of the National Alliance on Mental Illness (NAMI), and asked the parents the same thing. Often, religion came up in the answers. I did this until the time was further reduced to 10 minutes, 5 of which were needed for electronic health records (EHRs), and then gave up on it, deciding to retire from that medical school, feeling business ethics had ended up preempting healthcare ethics and spirituality.

I also worked part-time in a medium-security men's prison the last few years before I retired in 2012. There, I encountered a couple of Christian challenges to clinical care. One was a request for exorcism, and I wondered whether that was a unique therapeutic technique for a religious problem and/or a psychological technique for an underlying psychological problem like a dissociative disorder. Moreover, there may even be a Jewish connection that predates and leads to the Christian belief, as the historian Josephus (first century CE) conveys that King Solomon, the son of the Jewish King David, was known as an exorcist, knowing how to expel demons. Also, for the first time, I used the word "evil" in describing a patient [15]. This was a patient incarcerated for a killing and a love of dead bodies, sort of a variety of necrophilia. Despite attempts to find a psychiatric diagnosis for him or connect this to some other explanation, all I could come up with was that

maybe he was "evil" in the Christian sense of the word, a word I rarely heard in my Jewish circles (Fig. 19.2).

As I explored evil more as time went on, I found a great congruence between the views of Freud, who was Jewish, and his onetime protégé Jung, who was Christian, on what evil was all about. Both thought that evil was in our unconscious. Freud rarely wrote about evil, but as he once told a patient: "the moral self was the conscious, the evil self was the unconscious" [16]. Jung, too, thought evil was in our unconscious, and discussed it a lot, deciding that it was a part of a broader, collective archetypical expression of the dark side of the human psyche, our shadow [17]. Both emphasized that we had to recognize the evil in our unconscious selves in order to tame it. Perhaps with my prison patient, I just didn't have the time to be able to get to the unconscious evil aspects driving his conscious thinking and behavior. He was transferred to another prison after I saw him about four times. Though it seems doubtful that this unconscious conception of evil was recognized in the popularity achieved by the connection of Judeo-Christian values, that is certainly

**Fig. 19.2** Evil comes a-calling in its Sunday hat. Digital collage by Barry Marcus

consonant with George Orwell's use of the term in relationship to the unconscious forces fostering anti-Semitism.

In the Jewish religion, there is a basic belief that we are born both with an impulse toward good, the yetzer hat, and an impulse toward evil, the yetzer hara. It is our free will that can guide us more toward the good. In the more mystical interpretations, evil is contained in the shards of the special vessels that broke during creation, and can be fixed by the contemplative performance of religious acts. In Christianity, it seems to me that there is a concept that the Devil can take over one's mind, often with cooperation, to do evil. Both concepts would seem to overlap with the psychiatric ones.

Going back to my birth as a Holocaust-related child, the Holocaust has been called the most evil regime in history. The Christian churches, like most organizations, did little to resist the Nazis [18]. Then, again, Freud himself, the analyzer of the unconscious, seemed to ignore the risk to him and his family and got out just in time, but only after his beloved daughter, Anna, was brought in for questioning. Is evil hard to spot or so frightening as to be consciously denied?

I still love jazz music and am working on a chapter for another book on blind Black-American blues, gospel, and jazz musicians. My wife and I go to weekly Torah study and I am on the board of various Jewish organizations. My daily meditation in the morning is that of the Franciscan priest, Richard Rohr, from the Center for Action and Contemplation. Interestingly enough, he developed the concept of "edge leadership," which was then picked up by the journalist David Brooks, emphasizing the potential importance of straddling leadership in institutions, cultures, and faiths. That seemed to fit me.

By the end of the 1990s, patients could find out more about a psychiatrist's background online, which basically cancelled any attempt to be more of the previously recommended Freudian blank screen. Occasionally, patients with fundamentalist Christian beliefs questioned whether they could be helped by a Jewish psychiatrist, not having much choice in a public clinic at no charge. I did know that there were psychiatrists who called themselves Christian psychiatrists and tended to incorporate Bible study and interpretation in their clinical work, but there were none to whom I could refer such a patient. For reassurance, I used a variation of a saying that I found came from a traditional Jewish source, the Talmud [19]:

From here we learn that doctors were given by God the power to heal." (Talmud Bava Kama 850)

That seemed to work sometimes, but that is my own subjective speculation. I wonder if somehow we need some solid comparative outcome studies of different patient and clinician matches as far as religious backgrounds go. Does matching for religious background produce better outcomes than those where religion differs between patient and clinician? What about outcomes for atheist clinicians and religious patients?

## Racism

The latest psychiatric social challenge is the reemergence of racism as a societal problem. Although there is a significant percentage, perhaps 10%, of "Jews of Color" nowadays, racism generally refers to Black people who tend to be Christian. Indeed, Christianity seemed to be a great source of solace for those slaves who came from Africa, though there were differences in how Black Christianity developed [20]. For instance, Black Christians tend to apply their faith more in ways that challenge racial inequities. On the one hand, historically religion was used to justify racism, while on the other hand, Christianity could also be a source of liberation theology. Personally, given my Jewish emphasis on the value of Tikkun Olam, healing the world, I resonated most with Christian liberation theology and action.

Certainly, in terms of Black people, being Christian did not seem to translate into having the societal status of white Christians. Currently, white Christians of the alternative right are racist toward both Black Christian people and Jewish people. Though back when cultural psychiatry got began, Jewish and Black psychiatrists worked well together, that does not seem to be so much the case anymore. Even with my own history of over 40 years of addressing racism, currently young Black psychiatrists want to exclusively take leadership in addressing the topic of racism.

## Religious Groups of Psychiatrists

Perhaps there was never an APA group of Jewish psychiatrists because of the strong historical presence of Jewish psychiatrists. Nevertheless, by now, I wonder if we need one due to the rising anti-Semitism in the United States and the world, including increasing numbers of neo-Nazis in Germany.

When we held those multi-faith symposia, I came to know of the APA's Caucus of religion, spirituality, and psychiatry. But I was puzzled why I had not known of it before or become a member. Was it oriented toward one religion? Did it not recruit? As it turns out, there are similar groups in the professional bodies that regulate psychiatry in other countries such as the Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group (SPSIG) in the United Kingdom that was founded to provide a forum for psychiatrists to explore the spiritual challenges presented by psychiatric illness, and how best to respond to patients' spiritual concerns.

## Conclusions

In looking back now, it is clear to me that our multiple psychiatric initiatives would not have succeeded if they were not multi-faith and/or multicultural, in the very least because I could never have become knowledgeable enough and trusted enough on my own. Among other things, we succeeded with:

1. Embedding cultural psychiatry education into all residency programs
2. Increasing the religious interest and diversity of psychiatry
3. Producing unique multi-faith edited books on neglected subjects in psychiatry

For me, what I think helped this work was:

- Tolerant parents
- A beloved wife with a solid Jewish identity
- Admirable celebrities in sports, music, and other fields who were of other faiths and cultures
- Shared leadership and knowledge with other psychiatrists from different faiths and cultures

Where does this now leave me and psychiatry in terms of religion and spirituality? Certainly, psychiatrists are more religious and spiritual than in the past. In work with my Rabbi son, such as in leading an educational series on Jonah and the Whale from the Bible from both a religious and psychological perspective, there is more overlap in our fields. Nevertheless, as the United States has become increasingly more multicultural and multireligious, is that enough? Are we still a Judeo-Christian nation with common values? If the term is applied once again as George Orwell did, then those values should help to reduce the racism of persecution and intolerance that still exist for Black Americans, Native Americans, and other minority groups. Or is it just Christian dominated? Or interfaith? At least in this volume, we are considering the specific role of Christianity in psychiatry as a current baseline for its role in psychiatry.

There have been sporadic attempts to expand our bio-psycho-social model to bio-psycho-social-spiritual. If that becomes more accepted and formal, it might further enhance the role of religion and spirituality in patients and society.

I used to think that religion began where psychiatry left off, or vice versa. Now, I think what is most important is where they meet, the junction of psychiatry and religion, perhaps, to my surprise, even most cogently in the concept and concern with evil. I am left with the mystical mystery of synchronicity, examples of which have begun almost daily over the past year. Even the Jewish concept of Tikkun Olam has both a practical and mystical implication, practical in the sense of social action for justice, and mystical in the sense of rectifying the brokenness of creation by separating the holy from the created world. There are theories about how such synchronicity can happen, such as a four-dimensional block of space time where the future may exist along with our past and present [21]. I can't scientifically prove it, but I'm sure there are connected practical and spiritual connections to my professional career that confirms that I have been trying to do what I am supposed to do in this lifetime. Working on this chapter and book is not only providing more confirmation of what gives my life meaning but provides some new thoughts about how interfaith relationships can help prevent another Holocaust (Fig. 19.3).


**Fig. 19.3** Tikkun Olam/heal the world. Digital collage by Barry Marcus

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# Chapter 20
# Christianity from a British-Muslim Psychiatrist's Perspective


**Ahmed Hankir**

## Introduction

*Why am I as I am? To understand that of any person, his whole life, from birth must be reviewed. All of our experiences fuse into our personality. Everything that ever happened to us is an ingredient.* Malcolm X

Malcolm's words ring true with me although I do have a point of contention with them. I would argue that events that occurred even before my birth strongly influence who we eventually became and our vulnerability to developing mental health disorders [1]. I am also sure that epigeneticists amongst us would say that influences that occurred in utero also played an important role [2].

In this chapter I will provide background information about myself to discuss Christianity from a British-Muslim psychiatrist's perspective and describe the influences in my personal life that shaped my values and attitudes towards Christianity in general (and other religions) and my worldview.

I think a good starting point would be my paternal grandfather Ahmed Hankir, also known as Abu Adel, who was born in 1902 in the ancient Phoenician port of Sidon, which is situated in present-day Lebanon (as is the tradition in Middle Eastern culture, I was named after my grandfather). *Jeddo* (which is grandfather in Arabic) Abu Adel migrated from Sidon to Haifa in 1918 joining his aunt who had rented a dilapidated building in the city to shelter Sidonians who moved there seeking work. That same year, Haifa was seized from the Ottomans by the British. Under the British mandate, with the help of a branch of the Hejaz railway that opened under Ottoman rule, Haifa prospered and became a gateway to Saudi Arabia. The

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city was often referred to as *Amerka el 'areebe*, or 'nearby America'. Many Lebanese moved there for economic opportunities.

Abu Adel would sell fava bean stew or *ful medames* for a living. He would prepare this dish overnight and scoop it up into containers he would dangle from one side of the donkey (the other side was reserved for hummus). He would then travel to neighbourhoods along unmarked roads in and around Haifa to sell these products to the people in the villages of Hawasa and Balad al-Shaykh. Abu Adel sold *ful medames* from the back of his donkey for a decade, until he saved up enough money to buy land for a home in Haifa. Finally, in 1928, he opened a *ful* shop on al-Muluk Street (also known as Stanton Street) in Haifa, which is where his first two children were born. In 1948, my grandfather was expelled from his home during the Battle of Haifa and forced to join the Palestinian exodus, which saw him flee back to his hometown Sidon with his wife and children. My father Dr Zakaria Hankir, his third child, was the first to be born in Sidon.

My father excelled in school and secured a scholarship from the Gamal Abdel Nasser Foundation to study medicine in Cairo Medical School. Gamal was the charismatic President of Egypt at the time and had a vision for a better future for people in the Arab world. To this day, my father's clinic in Sidon is full of pictures of Gamal and other famous Egyptian leaders. Unfortunately, relations between Muslims and the Coptic Christians were tense, and when my father was in the throes of nostalgia, he would recount stories of how the Coptic Christian examiners would fail him despite his vast amount of knowledge because he was a Muslim. For example, my father reports that he had a viva with an examiner who was a Coptic Christian and was notorious for his Islamophobic attitude. During the viva, my father answered every question his examiner posed. The examiner then asked my father, 'From which textbook did you acquire your knowledge?' to which my father duly responded. The examiner then retorted, 'Do me a favour, cut the textbook into small pieces, put the fragments into a jug of water and then drink the concoction', and then he failed my father outright. Before leaving the examination station, the examiner asked my father if he had any questions to which my father replied, 'Do you know the water you asked me to fill the jug that contains the fragments of the textbook with, should it be hot water or cold water!?' There was no way to prove that the Coptic Christian examiner who failed my father did so because my father was Muslim, but as mentioned above, relations between Muslims and Christians in that part of the world at that time were tense, and religious discrimination in universities, the workplace and politics was not uncommon.

## 'Out of the Frying Pan and into the Fire'

My father qualified as a physician in the early 1980s when the Lebanon-Israel war was raging. This was a major factor that influenced his decision to migrate to Northern Ireland where another conflict was taking place, 'The Troubles'. However just before he left Lebanon behind, he met my mother in a village; they married and travelled together to Belfast. My mother would say to me, 'Son, it was like jumping

out of the frying pan and into the fire!' Indeed, Belfast at the time was considered one of the most dangerous cities in the world, and, 'The Troubles' – an ethnonationalist conflict that lasted for 30 years from the late 1960s to the late 1990s – continues to influence the mental health of people in Ireland to this day [3]. A key issue of 'The Troubles' was the constitutional status of Northern Ireland. Unionists, who were mostly Ulster Protestants, wanted Northern Ireland to remain within the UK. Irish nationalists, who were mostly Irish Catholics, wanted Northern Ireland to leave the UK and join a United Ireland. Although 'The Troubles' were perceived as a religious conflict (and the terms *Protestant* and *Catholic* were often used to refer to the two sides), historians argue that the conflict was primarily political and nationalistic, fuelled by historical events.

## The Sabra and Shatila Genocide

Against this backdrop, on the 15th of September 1982, I and my twin brother Mohammed Hankir were born in Belfast Maternity Hospital. The following day, on the 16th of September 1982, the infamous Sabra and Shatila genocide took place that involved up to 3500 civilians who were mostly Palestinian and Lebanese Shiites. They were massacred by a militia allied to the Kataeb Party (also called Phalange), a predominantly Christian Lebanese right-wing party, in the Sabra neighbourhood and the adjacent Shatila refugee camp in Beirut, Lebanon. Generations later, memories of those dark days continue to haunt all who were involved, i.e. the Lebanese, the Palestinians and the Israelis who were occupying Lebanon at the time [4]. The adverse effects of the Lebanon-Israel war on the mental health of those affected are well documented in the literature [5].

From Belfast, the family moved to Dublin, and from there we relocated to England where we would spend the next 6 years. However, despite the devastation from the war in Lebanon, my mother longed to return as she understandably missed her family immensely. So, in 1995 when I was 12 years of age, my parents returned to the war-torn land that my parents called 'home', and we accompanied them.

## 'The Wonder Years'

The 'formative years' (or, as I would call them, 'The Wonder Years') was a fascinating period in my life. I did not speak Arabic at the time and I very much felt like an 'outsider'. The native Lebanese people would even call us *ajnabi*, which is Arabic for foreigner or stranger, when they discovered that we were not proficient in Arabic and that we were born and raised in Ireland and the UK, respectively. There were no secondary schools that had a British curriculum, so our parents enrolled us in a secondary school that had an American curriculum (the Lebanese American School), and this is when I first heard the American accent, which at the time was incomprehensible to me! Although the school was 'American', it was really a melting pot.

There were pupils from all over the world including Australia, Colombia, Venezuela, Canada, Brazil and Sierra Leone. I soon learned about 'forbidden love'. In Islam, a man is permitted to marry a 'person from the book' (i.e. Christian or Jew), providing that the children are raised as Muslim. Bearing in mind that Lebanon was brutalised by a devastating civil war, this added another dimension to interfaith relationships and to 'broken hearts' since this barrier commonly prevented a Muslim lady from marrying a Christian man (such people would populate the clinics of psychologists and psychiatrists in Beirut).

## Return to the UK

I graduated at the top of my secondary school class in Lebanon. However, the Lebanon-Israel war had long-term and far-reaching ramifications, and the economy was crippled so that my prospects were not favourable. My parents therefore decided that I and my twin brother Mohammed should return to the UK. We were only 17 years old when we left our family behind us in Lebanon, and I am still processing the trauma to this day. Saying goodbye to the people who meant the world to me at such a young age had profound effects on my psychological well-being, and so much pain is still repressed and suppressed in my unconscious mind.

Upon my arrival on British shores, I was, legally speaking, not even an adult. My mind was still maturing, my brain was still developing, and my heart was still growing. Even though I was a British national, I would not be able to enrol at university as a 'home student' without residing in the UK for at least three consecutive years. Otherwise, I would be considered an 'international student', and the tuition fees would be exorbitant. Moreover, my qualifications from Lebanon were not recognised, and if I wanted to 'realise my dream of becoming a doctor', I would have to get straight A's in the A-level exams which usually take place over 2 years.

In my first year in the UK, I worked as a janitor cleaning floors in the morning and a stock advisor stacking shelves in supermarkets during the day and night. I would work 70 hours per week receiving minimum wage to survive, and the callouses on my hands were a testimony to my toil and labour [6]. During this time, I was quite oblivious to how secular the UK is. Although Christianity is the dominant religion in England, 'the people', by and large, do not really have any interest in religion. Indeed, a recent report revealed that Britain is becoming increasingly secular as a nation and that, *'counter-cultural religion, be it Christian or Muslim, is thriving in the UK…'* [7] The results of surveys have supported this assertion and shown that the UK is amongst the least religious countries in the world. Indeed, in a global ranking of 65 countries, the UK ranked 6 places from last, with only 30% of the population describing themselves as religious [8]. When Tony Blair was Prime Minister of England, his Director of Strategy and Communication Alastair Campbell once famously interrupted him when the Prime Minister was in the

middle of a soliloquy professing his love for Christianity, and Campbell emphatically exclaimed, 'We don't do God!' [9] I noticed and was told that many of the churches in the town centre had been converted to night clubs since there was a shortage of congregants attending mass.

Nonetheless, the people I met who were devout Christians were always very respectful towards me, and I felt that I had a profound understanding and connection with them. It became clear through multiple discussions that Islam and Christianity had much in common. Examples are how much both Muslims and Christians revere Mary, the mother of Jesus, and how both of our faiths believe in the Immaculate Conception. There is a chapter in the Holy Quran entitled, 'Mary'. Indeed, Mary is one of the most honoured figures in Islam, and Muslims view her as one of the most righteous women to have ever lived. Muslim women look up to her as an example.

Despite working full-time hours to keep a roof over my head and food in my stomach – which was a constant threat to securing the grades necessary to enter medical school – I received straight A's in my A-level exams and matriculated into Manchester Medical School. My twin brother received an offer to read medicine at Leeds University. However, he was not able to obtain the necessary exam results. Mohammed ended up studying neuroscience at university, and he 'switched on' during his undergraduate years. He would study day and night and develop a deep passion for neuroscience. Mohammed went on to obtain a postgraduate degree at University College London, a PhD at Imperial College London and a postdoc at Oxford University. Interestingly, although I developed a debilitating episode of psychological distress characterised by profound oscillations in mood and impairment in academic and social functioning whilst at university, Mohammed was relatively spared. I attributed my 'breakdown' partially to the hostile environment at medical school and the 'hidden curriculum'; the competition between students was fierce and this had adverse effects on my mental health. Although I and Mohammed are identical twins, we know that concordance rates of mental disorders in monozygotic twins are not 100% and that environmental factors and psychosocial stressors play an important role in the development of mental health conditions [10]. Our personalities, however, are similar and I would consider Mohammed my closest friend. Mohammed went through similar trials and tribulations; he had to wipe tables, clean floors and stack shelves to survive, and he also had to overcome many obstacles to achieve his life goals and progress with his career. Mohammed is also a devout Muslim (he has read the Quran in English and Arabic many times over and adores praying *taraweeh* (night prayers) in the mosque during the blessed month of Ramadan). We also have the same approach to Christianity and other faiths which I feel emphasises how our life experiences have shaped our values. The world is a better place with Dr Mohammed Hankir in it and for that I am grateful to God.

## Christian-Muslim Relations

Because of my background and life experiences (I had seen first-hand the destruction that had been wrought in the name of religion), I was always willing to learning more about Christianity with 'an open heart and an open mind', and I became a champion of peaceful co-existence. Moreover, Islam taught me to have the utmost respect for Christianity as exemplified in the letter below from the Prophet Mohammed (PBUH) to the monks in the Monastery of St. Katherine in Mount Sinai in the year 628. This letter contained 'The Charter of Privileges to Christians', in which Muslims were exhorted to protect the Christians living amongst them:

*This is a message from Muhammad ibn Abdullah, as a covenant to those who adopt Christianity, near and far, we are with them.*

*Verily I, the servants, the helpers, and my followers defend them, because Christians are my citizens, and by Allah! I hold out against anything that displeases them. No compulsion is to be on them. Neither are their judges to be removed from their jobs nor their monks from their monasteries.*

*No one is to destroy a house of their religion, to damage it, or to carry anything from it to the Muslims' houses. Should anyone take any of these, he would spoil God's covenant and disobey His Prophet.*

*Verily, they are my allies and have my secure charter against all that they hate. No one is to force them to travel or to oblige them to fight. The Muslims are to fight for them.*

*If a female Christian is married to a Muslim, it is not to take place without her approval. She is not to be prevented from visiting her church to pray. Their churches are to be respected. They are neither to be prevented from repairing them nor the sacredness of their covenants.*

*No one of the nation (Muslims) is to disobey the covenant till the Last Day (end of the world)* [11].

Inspired by the example of the Prophet Mohammed (PBUH), I wanted to socialise more with Christians and learn about their faith. I found it a lot easier to do this in the UK than in Lebanon, for reasons already mentioned above. For example, I would go to the Christian church on Sundays, and the pastor would always welcome me. I saw and felt the love the people had for each other and I felt accepted by them. Although Islamophobia is rife in the UK [12] and there were many occasions I felt I was perceived as a threat to society (once after the 9/11 terror attack, a man in a vehicle lowered his window and shouted at me, 'Bin Laden!', spat and then sped off) [13], *I never* felt that way whenever I attended church.

I do, however, want to be clear lest there is any ambiguity. I never considered renouncing Islam, not for a moment. As I mentioned above, the purpose of attending church was to learn more about the Christian faith. I think I also wanted people to learn more about the Islamic faith (i.e. perhaps a part of me wanted them to attend Mosque in the same way that I attended church so that they would learn the beauty of Islam and appreciate how much we have in common). However, what I

noticed was that although I would feel accepted and valued, the Christians I met in church seldom if ever showed any willingness to learn about Islam. I surmised that this might be because penalties for apostasy in Islam deterred the Christians I met from wanting to learn more about this monotheistic religion (i.e. renouncing your Islamic faith and embracing Christianity, is punishable by death in certain countries).

## Providing Mental Healthcare to Christian Patients as a Muslim Psychiatrist

The National Health Service (NHS), the publicly funded healthcare system in the UK, was established in 1948 as one of the major social reforms following the Second World War. The founding principles of the NHS were that services should be comprehensive, universal and free at the point of delivery. The NHS operates from a largely secular framework that excludes religiosity and spirituality, and this strongly influences how I provide mental healthcare to patients. For example, in Lebanon I would be at liberty of saying to a Christian patient with psychosis that *inshallah* (God willing, an expression that Muslims and Christians both use), they will recover. If I were to say the same phrase in the UK in the English language to a Christian patient, then I would run the risk of having my licence to practice medicine revoked. For this reason, although I would consider myself a psychiatrist who understands how valuable faith is for people and how this can contribute to mental health resilience and recovery, I trawl this precarious territory extremely carefully. I might inquire, for example, if they do practise Christianity since this can be a protective factor against suicidal behaviours when in crisis. However, again I would be vigilant when asking this question since people with a mental health condition can be vulnerable and impressionable and there have been reports that practitioners who identify as religious have unduly influenced their patients, the consequences of which can be serious.

There was a scenario in which I was engaged where a patient from a minority ethnic background was transferred to the emergency department via ambulance services with florid psychosis. His mother arrived later on, and I explained to her what I suspected her son was experiencing. The mother, who reported that she was a devout Christian and who was carrying a copy of the Bible with her, asked if I thought that her son was possessed by a malevolent spirit. I re-iterated to the mother that her son was likely experiencing a psychotic episode possibly exacerbated by illicit substances and that we would need to ask the medics in the emergency department to rule out any organic causes for his presentation. The mother met with her son in the cubicle and asked if she could pray for him and began to do so. What ensued, however, was astonishing. Suddenly the mother forcibly placed her hands around her son's throat and, 'in the name of Jesus', attempted to cast out the evil entity that she believed possessed her son. I immediately intervened and,

fortunately, members of staff in the emergency department were also present nearby. This scenario reminded me that members of the Christian community may attribute mental disorders to supernatural causes, although this is certainly not as common as in the Muslim patients to whom I have provided psychiatric care.

By and large, I have not experienced any overt Islamophobia from colleagues or patients in my capacity as a Muslim psychiatrist. My name may betray my faith, but I am clean shaven, and I would not be considered visibly devout. I have always been able to pray my required prayers at work (a space would even be created for me in the chapel at the workplace if a Muslim area of worship were not available). Unfortunately, the same cannot be said about many Muslim women mental healthcare providers who wear the hijab (veil) as they are visibly Muslim and are perceived as vulnerable and 'an easy target'.

## Conclusion

In this chapter I have provided background information about the influences that have shaped my attitudes towards Christianity and other religions as a British-Muslim psychiatrist in the UK. Being born in Belfast during 'The Troubles' and being originally from Lebanon where the Sabra and Shatila genocide took place have afforded me with a deep appreciation of the destruction wrought by people 'fighting in the name of religion' and the adverse effects this can have on mental health. My life experiences have inspired me to have an 'open mind and an open heart' and 'a humble faith' when learning about Christianity and other religions. Islam teaches us to value, respect and, whenever necessary, 'protect' Christians, and my experiences at work as a British-Muslim psychiatrist in the UK, a country that is becoming increasingly secular, has largely been a positive one. It is important for Muslim mental healthcare providers to bear in mind that although it is not as common as in other religions (i.e. Islam), there are segments of the Christian community that attribute mental disorders to supernatural causes. The NHS largely operates from a secular framework, and more guidance on how to provide faith informed care without transgressing any moral, ethical, religious or professional boundaries is urgently needed.

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# Chapter 21
# A Christian Psychiatrist's Perspective


**John R. Peteet**

I was the oldest of six in an upper middle class, white evangelical home in Atlanta during the turbulent 1960s, and came to faith as a child. After graduating from a newly integrated high school with a large Jewish contingent, I attended Wheaton College in Illinois, a Christian school with the informal motto "all truth is God's truth." While taking premed courses, I acquired a lasting interest in philosophy from my roommate, who has since become a Kierkegaard scholar. Seeing a wide range of patients in the first year of medical school in New York City induced a fascination with psychiatry, which seemed to offer a comprehensive vision of being human, and ways to understand people more deeply. My curiosity was intensified by an uncle who became paranoid unless he took medication, and by my namesake, a close family friend who became seriously depressed late in life to the point of doubting his faith.

Mentors during residency in Boston such as Leston Havens and Elvin Semrad inspired me by the ways they talked with patients about their core concerns in everyday language rather than in clinical terms.

Consultation/liaison and addiction psychiatry have always appealed to me for their broad concern with the human condition. Early in my hospital practice, I was impressed by how many oncology inpatients struggled with spiritual concerns that went unaddressed by their medical team [1] and, in my outpatient role, heard from callers asking for a "Christian psychiatrist" who could understand the importance of their faith. Both experiences seemed to reflect historical tensions between Western psychiatry and Christian faith. While many of Freud's followers shared his view of religion as an immature form of coping, conservative Christians often feared both this bias and being treated as simply having a "chemical imbalance."

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Over time, I noticed that faith could have other implications for Christians. Some wondered whether being depressed or anxious meant that they were lacking in faith. Others who had been disappointed by faith leaders they trusted felt no longer able to believe in God, and grieved the loss of that relationship. Some struggled to reconcile their same-sex attraction with what the Bible seemed to say about homosexuality, and to find a community in which they could belong and worship. Still others felt disappointed and/or betrayed that God had not spared them suffering. Seriously depressed patients sometimes felt condemned to hell, and psychotic patients sometimes believed they were prophets.

Sometimes I could help these individuals find a spiritual resource for dealing with the sources of their distress, such as a pastor within their tradition. At other times, this was impossible because they could not trust any religious authority. Many patients' emotional and spiritual struggles were so intertwined that it appeared they must be considered together.

Over time, I also came to appreciate what Christian faith itself could provide as a resource for living well. Having a relationship with Jesus was transformative for some, and deeply sustaining for those who were moved by his life and parables – such as that of God embracing the prodigal son. (I also had the example of my father, who as the descendent of slaveowners and KKK members experienced a conversion in college, started a school which he wanted to be open to all, taught in a Black Bible college, and tried to have his Black friends seated in restaurants, which were segregated at the time.) Some of my patients felt grounded by participating in a church, or a smaller group centered on sharing and praying about their concerns. Sermons and Christian education had inspired many to serve rather than to be served, to grow in character (the "fruits of the spirit"), to pass on what they were grateful to have been given, and to work for justice for the poor. Those whose traditions emphasized scholarship and study found coherence in the created order. Many were moved by the beauty of music and liturgy to find joy in surrendering to a God much greater than they. Sharing these experiences often seemed to help strengthen relationships with inevitably flawed spouses, making humility and forgiveness more possible.

The task of integrating these perspectives remains challenging for me, my patients, and our field, but has been made less daunting by a succession of clinician scholars. Allen Bergin [2] was among the first to articulate the therapeutic implications of a theistic as compared with an atheistic worldview. David Larson [3] and later Harold Koenig [4] have called attention to the large amount of research demonstrating the health benefits of religious faith and practice. Dan Blazer [5] clarified the social and spiritual dimensions of major depression. The Boston psychoanalyst Ana-Maria Rizzuto [6] deepened our understanding of Freud's treatment of religion by exploring the development of every person's internal representation of God. John Swinton demonstrated the relevance that a Christian perspective has on dementia and disability [7], and Warren Kinghorn [8] demonstrated its relevance in the treatment of moral injury and PTSD. Positive psychology and the study of human flourishing by researchers such as Tyler VanderWeele [9] have highlighted the role of virtues including gratitude, forgiveness, and love. The annual Conference on

Medicine and Religion has become a place to better understand the distinctive clinical implications of the Abrahamic religions Christianity, Judaism, and Islam.

Cultural forces and forceful individuals have long recruited Christianity to justify colonialism, slavery, war, and capitalism; support for misogyny, anti-Semitism, Islamophobia, and homophobia; and distortions such as the "health and wealth gospel." Perhaps most relevant to clinicians are the uses made of scriptural passages to condone and perpetuate abuse, for example, with the command "Children obey your parents." The more we know as therapists about the meaning of such passages in their context, the more we have to offer victims of abuse to gain a needed perspective. Also, the meaning of scriptures about guilt and forgiveness often helps those depressed or traumatized individuals feeling unable to forgive themselves. This includes scriptures on self-sacrifice for those vulnerable to masochism or codependency.

A major cause of division among churches worldwide in recent decades, and of pain for many individuals for centuries, has been the moral status of sexual and in particular same-sex relationships. Traditional Christians object to these because out of what they believe scripture teaches, while more liberal Christians actively affirm LGBTQ+ identities and choices. Meanwhile, a smaller third group has worked to make space within the church for contrasting positions on such nonessential issues [10]. Clinicians working with same-sex attracted patients raised in a conservative church often need to help them understand all of the options they have within the Christian tradition.

As a therapist helping patients aim for a more satisfactory life, I need a vision that extends beyond symptom relief or more autonomous functioning [11, 12]. As a Christian, I see all individuals as beautifully created by God, loved in their brokenness, and capable of transformation and joy in response to God's initiative to engage them. In practical terms, this means prioritizing loving and being loved among other virtues that contribute to living a full life [13, 14]. It also means living accountably, including before God, rather than being answerable only to oneself – a reason why Christian couples in crisis often seek out therapists who will appreciate the value they place on marriage.

So, to help a patient enhance their flourishing and mental health, I need to assess how engaged they are with their faith, where it could be more active, and what is interfering with this process. A patient with complex PTSD may need to be supported through her grief over losing belief in God long enough to feel loved and able to trust others again. A patient with major depression who feels alone in the world may need both treatment of her depression and exploration of what her faith meant to her before her mood was altered. A patient with lifelong struggles feeling connected to God and others may need to examine the quality of his early attachments. A patient with a vulnerability to psychosis may need to realize that taking an antipsychotic medication for the rest of their life need not indicate a lack of faith that God can heal. A Christian patient addicted to pornography may need to appreciate the importance of accountability to partners, of attending to his feelings, and of accepting God's forgiveness. A patient facing death may need help to appreciate the art of dying (*ars moriendi)* [15]. I understand taking steps to meet these needs as

following those of Jesus who as a Jewish prophet helped individuals engage the moral resources of their own tradition to live a fuller, more just, and compassionate life [16], and came to show them that they are known and loved by God. While I can hope that an atheist patient will experience God in this way, I see my role as helping him draw on his own convictions to move forward.

Working with patients in these ways has helped me vicariously to integrate my faith with the rest of my own life, sensitive to my own religious countertransference [17]. Other opportunities to learn have included teaching courses on spirituality and medicine; writing, reading, and discussing works of fiction; and collaborating with valued colleagues and students having diverse perspectives.

I'm aware of a number of remaining challenges: How can churches and Christian leaders become more open to mental illness and treatment? How can mental health professionals recognize the unique concerns and potential resources of their Christian patients? How can I (we) learn from other faiths including secularism while retaining the distinctives of Christian faith in approaching mental illness, disability, and suffering? How can I remain aware of my blind spots and needs for both God and science? How can we all learn from research on the benefits of faith and faith practices without endorsing an instrumental use of faith for its health benefits?

This multiauthored book aims to help us all move closer to a view of truth that is evidence based, clinically relevant, and informed by the wisdom of Christianity and its fellow traditions.

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