

Religious delusions



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Religious delusions are of fundamental significance in forensic psychiatry, and they played an important part in the birth of British psychiatry.

The birth of British psychiatry

In November 2011, BBC1, in 'Garrow's Law', revisited the case of William Hadfield, who shot at George III, intending to miss, on 15th May, 1800 ¹. Hadfield's madness was associated with, or precipitated by, severe brain damage from sabre wounds to the head sustained in Flanders in 1794, when he was one of the Duke of York's bodyguards. He had outbursts of extreme violence, during one of which he had threatened the life of his own child because, he said, he had been commanded by God to do so. He had a delusion that he must die to save the world but, because of his religious beliefs, this must not be from suicide. Therefore, in order to be hanged, he staged an elaborate mock-assassination attempt on the King at Drury Lane Theatre by firing a pistol at close range; an expert marksman, he missed by 12 inches! He was disarmed, arrested and charged with high treason.

Thomas, later Lord, Erskine defended him, and Dr Crichton of Bethlehem Hospital gave medical evidence; the enlightened Lord Chief Justice 'stopped the trial and directed the jury to find Hadfield 'Not Guilty: he being under the influence of Insanity at the time the act was committed''. The case of Hadfield changed thinking, and hence the law, on criminal responsibility. Later that same year, the law was changed so that Hadfield, as an insane person, and therefore not guilty of murder, could be detained indefinitely at Bethlehem, and so his *religious delusion* effectively initiated the practice of *forensic psychiatry* and subsequent framing of the *Mental Health Act*.

There was renewed interest in mental illness at the end of the 18th century and most historians, asked for a date for the beginning of psychiatry in Britain as a separate discipline, would put it about 1800. I would contend that *religious delusion*, with the Hadfield case, was the mid-wife for the birth of British psychiatry in 1800. Hadfield died in Bethlehem Hospital in 1841, the year the first antecedent of the Royal College of Psychiatrists was inaugurated.

To come to the present, in the literary world, when Sebastian Faulks, in his novel of 2009, *A Week in December*, donates schizophrenia to a character, what symptoms does he give him? Yes, that is right, religious delusions ².

What is delusion?

No definition is perfect. *A delusion is a false, unshakeable idea or belief, which is out of keeping with the patient's educational, cultural and social background; it is held*

*with extraordinary conviction and subjective certainty*³. One can argue with each clause, but delusion is a phenomenon that is outside normal experience, not ordinary.

According to Spitzer, delusions make *knowledge claims* and not *belief claims*⁴. Delusion is experienced as an everyday *notion* or *assumption* rather than a *belief*; in this it is quite unlike a subjective religious experience⁵. A deluded person quite matter-of-factly declares herself to be the Virgin Mary in the middle of a conversation about hospital food. It is not a credal statement but merely a comment on how the person views reality.

Delusions are always self-referent: the belief or notion always has something to do with oneself – and, of course, **my** religion, **my** spiritual belief is extremely personal. One does not have delusions about remote places or times without it having some reference to **me**. Delusions have generally been classified according to their content and *religious delusions* are just one of many, although frequent and often highly significant. Religion often forms the *content* of other types of delusion, for example, persecutory delusions or delusional misidentification.

The idea of being ‘out of keeping with the cultural and social background’ can cause problems: whose cultural and social background, the patient or the doctor? Obviously, the patient’s: it includes immediate as well as wider culture. So, the designation ‘Muslim’ or ‘Christian’ is not enough to describe the culture: a Christian from Nigeria who attends a Pentecostal church in east London does not share his socio-cultural background with an Egyptian Coptic Christian or a Home Counties Anglican.

A delusion is held *on delusional grounds*. Even though what is believed is factually correct, it is a delusion if the evidence on which it is believed is delusional.

Delusions are *held without insight*. If someone wonders if they are deluded or not, they almost certainly are not. A psychiatric colleague, after a long silence over lunch, said, ‘I suppose the difference between delusion and faith is that delusion is held without any doubt, but religious belief is held with some doubts, or at least an understanding that others could have doubts about what I believe.’

Those with religious beliefs accept that some of their phrases are spiritual and not to be taken literally, for example, ‘listening to God’ or ‘giving your heart to the Lord Jesus’. In some serious mental illnesses there are abnormal processes of thinking resulting in *concrete thinking*, a literalness of expression and understanding.

Religion cannot be a *shared delusion*. Psychopathologically speaking, delusion cannot be shared. Jaspers puts this: ‘Schizophrenics are not surrounded by a single schizophrenic world, but by a number of such worlds. If there were a single world-formation schizophrenics would understand each other and form their own community. But we find just the opposite. They hardly ever understand each other; if anything, a healthy person understands them better.’⁶ When there were long-stay patients who believed that they were Jesus Christ, this was not a shared delusion. Joseph Smith believed that Joseph Smith was Jesus Christ and Thomas Brown believed that Thomas Brown was. Thomas Brown never believed that Joseph Smith was Jesus Christ, nor vice versa.

Delusion is, in Jaspers' expression, *ultimately un-understandable*. This means that, even putting oneself in that person's position and seeing the world from their point of view, one is still unable to understand how they could hold *that notion* with delusional intensity.⁷

It has been stated that there is no difference between delusion and religious experience. This is to ignore the psychopathology; in some cases it may be difficult to distinguish, but these are the rare exceptions.

Why are delusions not infrequently religious?

I do not know the answer to that question and in that I do not seem to be alone. The psychiatric literature does not appear to answer the question, perhaps because the question is not asked. Having failed to find out from recent publications I returned to Jaspers, and his wise comment is: '*we may go beyond the empirical field and ask how there could be any meaning in the coincidence of religion and madness; could we interpret it that where the individual himself is in extremity, the extremity of his existing vital state provides a basis for meaningful experience.*'⁸ The implication here is that there is nothing more fundamental to 'who I am' and 'where I am' than my religious and spiritual beliefs.

Now a digression to discuss *form* and *content*: that it has a *religious nature* is always a comment on the *content* of a delusion; that it **is** delusion at all is comment on psychopathological *form*. The patient is only concerned with the content of an experience: content reflects the predominant thinking of the patient, for example, a person whose life has centred on money and fears of poverty, may well believe that she is being robbed. The form indicates the type of abnormality of mental experience; that is, the nature of the descriptive psychopathology. It **does** matter whether the religious belief that the patient holds is a delusion or not, as, if it is, it implies the presence of a serious mental illness.

Religious delusions do not only occur in people who are regarded as religious, involved in organised religion, church or mosque attenders and so on. For all of us our religion, our spirituality, even our absence of belief, is something fundamental to us, and it is the nature of delusion that the content is *of great personal significance* to the deluded person. This is true even for bizarre or apparently meaningless false beliefs. Revisiting Mellor's classical description of schizophrenic first-rank symptoms, here is one of his cases, *delusional percept*, chosen for its religiosity: '*A young Irishman was at breakfast with two fellow-lodgers. He felt a sense of unease, that something frightening was going to happen. One of the lodgers pushed the salt cellar towards him ... Almost before the salt cellar reached him he knew he must return home, 'to greet the Pope, who is visiting Ireland to see his family and to reward them. . . because Our Lord is going to be born again to one of the women. . . And because of this they (all the women) are all born different with their private parts back to front.'*'⁹

Delusions also reflect the background personal preoccupations of the patient – not necessarily the same as having significance. The delusion, and its content, has meaning for the sufferer, now. Glenn Roberts (1991) writes that delusions, in the context of schizophrenic illness, may be an adaptive response to whatever initiates

the psychotic break. A group of chronically deluded subjects was compared with previously deluded patients now in remission and with two non-patient groups. The chronically deluded group scored much higher than the remitted patients for positive meaning in life, and much lower for depression and suicidal intention. For some the formation of delusions is adaptive in combatting purposelessness and hopelessness and provides a new sense of identity and a change from fear, worry, depression and boredom towards feeling lively, enthusiastic, interested and peaceful. One patient described this: 'I've had a great time. I've got this one great thought in my mind that I am Jesus – that's enough . . . nothing hurts me now, I need nothing now . . .' ¹⁰

Do religious delusions invalidate religious belief?

What comment do religious delusions make on the nature and validity of religious belief? Very little, except that spirituality is a core belief for most people. This is dealt with more fully in my book, *Is Faith Delusion?* ¹¹ Is all belief delusional as Dawkins, without defining delusion, would contend? ¹²

Some people hold beliefs that others find false or even repugnant, but this does not necessarily make them delusional. Even for very bizarre and socially unacceptable beliefs there are reasons why they cannot be delusions:

- 1) They are not out of keeping with *that individual's* cultural and social background.
- 2) They are not necessarily held on *delusional grounds*.
- 3) Religious beliefs are **spiritual**, abstract, and not *concrete*, physical.
- 4) Religious beliefs are held with *insight*; the believer can *understand others not believing*, and he or she may have doubts.
- 5) For religious people without mental illness, bizarre thoughts and actions *do not occur in other areas of life*, not connected with religion.
- 6) Religious ideation and predominant thinking is a description of *content* and therefore, from the psychopathological point of view, irrelevant for *form*.

Neither having a spiritual belief nor experiencing serious mental illness is an uncommon event. So, inevitably, sometimes the two will coincide. That does not mean that one *caused* the other.

It is possible in the majority of cases to tell religious belief and delusion, as psychiatric symptom, apart ¹³. Religious belief and psychiatry are different from each other, and their concepts come from different world-views. A consideration of them in relation to each other is helpful and the two different perspectives have much to contribute to each other. Rather than being delusion, faith helps in the understanding of mental health and illness, and enriches psychiatry.

Delusions demonstrate permeability of self, possibly from right hemisphere disturbance

In schizophrenia a case can be made for considering delusion, and other Schneiderian first-rank symptoms, to be a disorder of the mental state affecting

boundaries of self, that is, a disturbance in knowing where 'I' ends and 'not I' begins. This occurs in other conditions but in schizophrenia, the sense of invasion of self appears to be fundamental to the nature of the condition as it is experienced; first-rank symptoms have in common permeability of the barrier between the individual and his environment, *loss of ego boundaries*¹⁴. There is a merging between *self* and *not self*, but the patient is not aware of the disturbance being one of ego boundaries; he describes a problem only inasmuch as 'other people are doing things to me; events are taking place outside myself'. The external observer finds a blurring or loss of the boundaries of self which is not apparent to the patient himself. All passivity experiences falsely attribute functions to *not self* influences from outside, which are actually coming from *inside the self*.

How about *religious* delusions? Do they demonstrate any permeability of self? I have already pointed out that the content of these delusions is of great personal significance and reflects background personal preoccupation of the deluded individual. They are personal in a concrete way; they are expressions of knowledge, not of belief, which is why delusional statements are expressed with conviction and certainty and not subject to discussion and inquiry¹⁵. In religious delusion, eternity and infinity have come within and are under the person's control. This is unlike the experience with non-psychotic religious beliefs, which are spiritual or metaphorical, usually discussed with others with thoughtful reticence and acknowledgment of our human limitations, and sometimes are held with doubts or at least understanding that others may have doubts.

To leave the certainties of psychopathology for the speculation of science for a bit, what have religious delusions to do with the brain? All mental activity involves both cerebral hemispheres but much of our discussion, above, has an emphasis on the right hemisphere. Our colleague, Iain McGilchrist, writes: 'The right hemisphere is concerned with finer discriminations between things, whether living or non-living.'¹⁶ It also has an advantage in dealing with visuo-spatial aspects of life. 'Most, if not all, of the 'functions' mediated by the right hemisphere fall into the category of what has to remain outside the focus of awareness – implicit, intuitive, unattended to. And so it looks as though *self-consciousness*, at least, comes about when the left hemisphere is engaged in inspecting the life of the right.'¹⁷

Michael Trimble has concluded that there is a slow accumulation of evidence in favour of religious experience being more closely linked with the right hemisphere, especially the temporo-parietal region¹⁸. Peter Fenwick came to a similar conclusion, associating religious experience with right temporal lobe activity¹⁹. Just a cautionary note – that is where religious experience is mediated; it is not the *cause* of religion. When I look at my beautiful and real, cherry tree in April, my visual experience is *mediated* through my occipital lobes – but the tree remains a fact.

'Self-awareness, empathy, identification with others, and more generally inter-subjective processes, are largely dependent upon...right hemisphere resources.'²⁰ All these are functions involved in religious belief and the practice of religion in co-operation with others.

The conclusion of much research is that schizophrenia and related disorders are associated with a disturbance and consequent hypo-functioning of the right cerebral hemisphere – the capacity for seeing the whole has been lost. For example, right hemisphere lesion appears to be associated with delusional misidentification²¹, and probably with other delusions.

Put all this disparate information together and the probability is that religious delusion is associated with disturbance in right cerebral hemisphere activity. Not being a believer in the religion of scientism, I hold this explanation lightly and with no emotional conviction.

Religious delusion and who I am

Religious delusions are not just a psychiatric idiosyncrasy, an exotic curiosity; they demonstrate profound disturbance in self-image, in who I am and how I relate to the world. We cannot apprehend this, as an insight of the psychiatrist into the inner life of our patient, without knowing, in empathic detail, about the religious and cultural background of the patient and the shared beliefs of his sub-culture. Bear in mind that, in the phrase religious delusion, *religious* involves the faculty of belief but *delusion* implies, as far as the patient is concerned, the mental faculty of *knowledge*.

Now look again at religious delusion. These are not philosophical or theological notions that concern other people; they are down-to-earth comment or description of things that matter to *me*, the patient, with religious colouring. The same delusional themes, including religious, are found everywhere, but the way in which they are elaborated depends partly on the patient's religious background²².

The delusion may be grandiose, particularly during a manic illness, for example, a patient who believed that she had been sent by God as a special person to the Birmingham Housing Department. It may be depressive, as in this patient of Emil Kraepelin: 'I wish to inform you that I have received the cake. Many thanks, but I am not worthy. You sent it on the anniversary of my child's death, for I am not worthy of my birthday; I must weep myself to death; I cannot live and I cannot die, because I have failed so much, I shall bring my husband and children to hell. We are all lost; we won't see each other anymore; I shall go to the convict prison and my two girls as well, if they do not make away with themselves because they were born in my body.'²³

Religious delusion may manifest the distinctive psychopathology of schizophrenia, as in Mellor's case already quoted. Whatever the form, it is always personal to the patient – 'I' feature somewhere within it; it always represents an abnormality of self and self-image, the way I see myself and position myself within my world.

Conclusion

The *religious* colouring of the delusion is seen as a *disorder of content* dependent on the patient's social background, interests and peer group. The *form of the delusion* is dictated by the nature of the illness. Religious delusions are not caused by excessive religious belief, nor by the wrongdoing which the patient may attribute as cause, but they simply accentuate that when a person becomes mentally ill his delusions reflect, in their content, his predominant interests and concerns.

Sometimes it can be difficult to make the distinction between religious delusion and the experience of an unusual religious belief or practice. Psychiatric morbidity would be suggested by the following:

1. Both the subjective experience and the observed behaviour conform with known psychiatric symptoms; that is, the self-description of this particular

experience is recognizable as being within the symptomatology of a psychiatric illness, for instance, it has the form of delusion. *An in-patient believed with complete certainty that everyone coming on to her ward in the hospital nodded in her direction because they knew, in her words, that she was 'a secret emissary of the Holy Spirit'.*

2. There are recognizable symptoms of mental illness in areas of life other than religion; these may be delusions, hallucinations, disturbance of mood, or thought disorder. *A person with religious delusions also believed that gas was being pumped through her front door and making her sporadically unconscious.*
3. The lifestyle, behaviour and direction of personal goals of the individual, subsequent to the event or religious experience, are consistent with the natural history of a mental disorder rather than with a personally enriching life experience. The manner of life is compatible with the conditions in which delusions occur. *An unhappy young man lived on his own without any occupation, in a filthy, chaotic one room flat. His only friends and contacts were in a local church. His life style demonstrated psychiatric disorder, irrespective of his beliefs, and other aspects of his conversation led to a clear diagnosis of schizophrenia being made.*
4. As already described, the thoughts, experiences and actions of a person with schizophrenia are often concrete, physical and not abstract or spiritual; beliefs may be acted on literally. *If he describes, 'Christ being in me', he might well be able to state in which organ of his body Christ could be located.*

Historically, religious delusion is intimately involved in the beginnings of psychiatry; *psychopathologically*, it is essential for diagnosis to unravel form from content; *socio-culturally* it gives the doctor an introduction into the world of the patient. Yet, it has often been neglected. I would like to see that redressed, and this is a start.

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