Dear Member,

Welcome to this edition of the Spirituality and Psychiatry Newsletter, No. 43, June 2017.

In this issue, you will find texts from the most recent SPSIG conference on Friday, 21st April 2017 at the Royal College of Psychiatrists, ‘Silent Prejudice: Stigma, Spirituality and Mental Health’. Our warm thanks to the speakers for their contributions on the day and for kindly provided texts for this Newsletter. The event, administered by CALC, the College’s Centre for Advanced Learning and Conferences was well attended, with 100 delegates.

The next conference of the SPSIG is again an open meeting, to be held at the College on December 8th 2017 entitled ‘Bringing Compassion into Mental Healthcare’. The programme organisers write:

To many of us at this moment, healthcare seems to lurch from one crisis to the next and morale of practitioners is being seriously affected. At times like this we need to ask ourselves the difficult question: how can compassion truly reach the heart of our healthcare organizations to deliver the kind of care we would all want to give and receive? This day will explore the meaning of compassion as it relates both to spirituality and a wide range of therapeutic approaches. We shall consider how compassion as a spiritual value can help bring about organizational and cultural change to benefit not only our patients but also ourselves as clinicians and the Health Service in which we work.

We think this is a vital subject for discussion, never more so than at the present time, so do join us if you possibly can. See under ‘Latest News’ on our homepage for the link to conference bookings (open now) and where full programme details will be posted in due course.

It is with great pleasure that we announce the award of the 2016 SPSIG Essay Prize to Dr Calum Miller for his submission ‘A case for informing patients of the mental health benefits of religion’. Even mental health professionals with a strong personal faith would hesitate to embark on such a discussion with their patients. Nevertheless, Dr Miller brings his rigorous philosophical mind to bear on the subject and argues with closely reasoned logic that patients are entitled to be given the evidence. Do read the paper, included in this issue of the Newsletter and see what you think!

Also included in this issue is the recent Position Paper of the German DGPPN Task Force on ‘Dealing with Religiosity and Spirituality in Psychiatry and Psychotherapy’. The DGPPN (German Association for Psychiatry and Psychotherapy, Psychosomatics and Neurology) is an influential body, and this paper, which addresses many of the issues that have exercised the minds of the SPSIG over the years, is an admirable and comprehensive document for which the authors deserve to be congratulated.

In this Newsletter you will find a valedictory reflection from Dr Paramabandhu Groves, who steps down as our Chair at the Edinburgh Congress, and a welcoming message from our incoming Chair, Dr Alison Gray, who succeeds Dr Groves this June. Thank you, Paramabandhu, for your thoughtful counsel and encouragement over these last three years and welcome, Ali, to the Chair - we are looking forward to your leadership and guidance during your forthcoming term of office.

As always, please let me have any articles you have written in Word, and send to Emma.Jacobson@rcpsych.ac.uk headed ‘for the attention of Dr Andrew Powell’.

With best wishes for a restorative summer break!

Andrew Powell (Editor)
From the Incoming Chair

Paramabandhu Groves will be a hard act to follow. His calm, thoughtful style has helped the Executive Committee (Exec) to think through challenging times and to consolidate our position as a source of significant teaching on spirituality in mental health. Thank you Paramabandhu!

We are glad to welcome Lucy Grimwade as the Exec secretary and Christopher Findlay to continue as treasurer. Thanks to them and to all the Exec members for their hard work.

The next few years will continue to be challenging in terms of austerity and of the many major changes our country is currently undergoing. Now, more than ever, people need to rediscover the resources that the great spiritual traditions offer to sustain and nurture the spirit of the caregiver under the tremendous pressure of the modern NHS.

The SIG is a diverse group and in the Exec we have members of the major religions and of the ‘spiritual but not religious’ demographic. Whilst we can all agree that there is much more to life than what we can taste, touch and measure and that spiritual practices are important in our own lives, our worldviews differ. Hence the SIG rarely takes a position on specific issues. Instead, we use our conferences to explore our different approaches and our common ground.

Feedback from our April meeting was overwhelmingly positive. The conference was well attended, with excellent speakers (and me), lively discussions and passionate expression of differing viewpoints on stigma, spirituality and mental health. Several people said they preferred the friendliness of the table layout, rather than lecture theatre style. We will aim to use the tables again when numbers allow.

We will have an open meeting during the RCPsych International Congress, as a platform for the SPSIG and for the Exec to hear the views of members. This will be in the Menteith Room at the Edinburgh International Conference Centre, Wednesday 28th June 2017, 12.45-13.40. A sandwich lunch will be provided (you must be booked into the congress on that day to be able to attend).

This follows the session S33 (11.30-12.45) where SPSIG members will be speaking on ‘The intersection of spirituality and mental health among diverse and disadvantaged populations’.

Our winter day conference is Friday 8th December 2017, ‘Bringing Compassion into Mental Healthcare’, with top rate speakers on compassion, and afternoon workshops to ground theory in practical application. Further information and bookings at http://www.rcpsych.ac.uk/traininpsychiatry/conferencetraining/conferences/spsigconference-dec2017.aspx
Whilst we welcome all-comers to our conferences, our focus is on encouraging psychiatrists to recognize the value of spirituality both personally and professionally, and to respond appropriately to spiritual issues raised by their patients/clients/service users. To this end, on 16th March 2018, our conference will be restricted to College members and fellows, to allow for more personal discussion and sharing of challenges. This will be a low cost event, with a maximum of 50 attendees; booking details will be circulated nearer the date.

Our winter 2018 conference (which will be an open event) is booked for Nov 9th 2018. Do save the date; further details to follow.

We acknowledge that our conferences are London-centred, and we look forward to supporting small groups from around the country in developing programs that the SPSIG Exec can endorse. These can then be delivered locally ‘in association with the RCPsych Spirituality and Psychiatry Special Interest Group.’ Please contact us via the College if you wish to discuss the possibility of an SPSIG meeting near to you. The Exec can help with suggesting potential speakers, advising on the program, and pointing out some of the potential pitfalls.

I am glad to take over chairing the Spirituality SIG and helping to build on the foundations laid by all the past chairs and its Exec and members. Please let us know what topics you would like covered, what your issues and challenges are and how we can best equip you. I look forward to hearing from you, and meeting you at forthcoming conferences.

Dr Alison J Gray
From the Outgoing Chair

I am told that sometimes people refer to the SPSIG - or at least its Executive - as the 'God squad'. I smile inwardly when I hear this. Perhaps they are unaware that for the last four years the SPSIG has been chaired by a Buddhist. For me personally, as a Buddhist, God has no particular significance. Buddhism is often referred to as a non-theistic religion. Not God, but also not atheism with the secular materialist connotations that can bring. The focus of reverence and worship for me is the Buddha - not a god, but not merely human. The Buddha was a human being who awakened, becoming a new category of being, which as an object of devotion can be hard to grasp to those used to the binary God/absence-of-God division.

I raise this because sometimes understanding how another person finds meaning and significance can be difficult. Spirituality as an umbrella term for an individual's source of meaning can be broad. Intolerance of differences in belief can cause strife and worse. I have felt privileged over the last four years to enjoy harmonious working with the Executive of the SPSIG, which includes individuals with a wide range of spiritual beliefs and practices. Tolerance has sometimes been described as the ability to disagree with someone without hating them for their difference in belief. My experience in the SPSIG is that we have not shied away from exploring differences in belief, including looking at the shadow or unhelpful sides of spirituality, as well as its benefits. Clearly this warm, interested, yet discerning curiosity, is a quality we need as psychiatrists to bring to our patients. With the recent troubles in the UK, it is a quality needed more widely within our society.

As I hand on the Chair to Ali Gray I wish her well in the role and hope that genuine tolerance is something that we can continue to foster in the SPSIG. I hope that as psychiatrists we can be of real benefit to our patients, and perhaps be of a wider benefit too.

Dr Paramabandhu Groves
I am going to give a brief introduction to the field of stigma and spirituality, my aim here being to offer a basic conceptual framework.

I witnessed stigma and discrimination in action, in my home town in June 2015.

The word stigma is directly from the Greek. Originally, in the first century CE, stigma meant a mark, tattooing, scarring or burning, which identified to whom slaves or soldiers belonged. Stigma came to mean: ‘An attribute that is deeply discrediting and reduces the bearer from a whole and usual person to a tainted, discounted one.’

The word stigmata is also derived from the Greek- referring to the marks of crucifixion on Jesus’ body.

Stigmatized individuals are labeled, set apart and rejected. They are associated with negative stereotypes and this leads to discrimination against them; hence they experience loss of status and reduced life opportunities.

Mental illness stigma has received a lot of press coverage since Prince Harry spoke out about his struggles following his mother’s death, and Prince William has advised that the traditional British Stiff Upper Lip is not always healthy.

So that’s it - job done, no more stigma anywhere, we can all go home... If only!

I was involved in the first college anti-stigma campaign ‘Changing Minds: Every family in the land’ in the early 2000’s. Things have improved, but there is a long way to go before those who have experienced mental illness are not discriminated against and mental health care is given the same resources as physical health care.

Today we are thinking about stigma, religion and spirituality. There are healthy and unhealthy forms of religion. For most people most of the time religion is good for their mental health and many service users and experts by experience find spirituality supportive and want it to be acknowledged.
My argument is that we should support service users to identify healthy religiosity and what helps them to flourish, and help them recognize and address negative unhealthy spiritualities which are destructive.

People with mental health problems are acknowledged to suffer discrimination in modern Britain. A 2013 You Gov poll put people with Mental health problems as the most discriminated against in Britain today.

Of course mental illness isn’t the only thing that is stigmatized. The same is true for those with visible disabilities, lesbian, gay bisexual and transgender (LGBT) people, deaf sign language users, people with epilepsy, HIV and sexually transmitted diseases.

Stigma is often associated with perceptions of threat, uncontrollability and dangerousness. At Halloween 2013, Tesco & Asda thought it appropriate to market a scary ‘psycho ward’ orange jumpsuit inmate’s uniform as costume. They did respond to protests and the costumes were withdrawn.

Because of stigma, people don’t tell others about certain conditions, so they are rarely discussed. This leads to ignorance and lack of knowledge in the community and to increasing fear, which stokes prejudice, a problem of attitude, and to active discrimination.

Discrimination against those with mental health problems lead to societal rejection, poorer healthcare treatment and health and economic disparities.

The lack of parity of esteem of mental and physical healthcare leads to poorer resourcing for mental health conditions.
Ultimately stigma and discrimination are behind the early death of so many with mental illness, 15-20 years earlier than people without mental health problems. 4

This is a common problem worldwide. For example Major Depressive Disorder (MDD) is a severe illness with high morbidity and high rates of suicide. Looking at people who had experienced MDD for more than 12 months in 21 countries:

60% of the individuals diagnosed with MDD recognized that they needed treatment, but less than 1 in 5 were adequately treated in high income countries, going down to 1 in 27 treated in Low & Medium Income Countries. 5

There are two main ways of looking at stigma; action orientated, and experiential.6

If we look at how stigma works through the action orientated lens, we can identify:
- **Structural discrimination**, which refers to discrimination through laws and policy: e.g. Mental Health funding
- **Public stigma**, which refers to the widely held negative stereotypes that lead through prejudicial attitudes to rejection and distancing oneself from those perceived to have mental illness.
- **Affiliate/courtesy stigma**, the way in which those who live with or work with the stigmatized group are also stigmatized to some degree. Affiliate stigma to some degree explains the poor attitudes held by some doctors towards psychiatrists 7
- **Provider stigma**, the way that healthcare systems and staff discriminate against those with mental illness.
- **Internalized/self-stigma**, the acceptance of diminished opportunities because the individual accepts societies stigmatizing judgment, and feels people with their diagnosis can’t achieve or don’t deserve any better.

From the experiential viewpoint, stigma can be subdivided according to what is experienced into-
- **Perceived stigma**, what is considered to be most people’s view of those with the stigmatizing condition
- **Endorsed stigma**, when people agree with stigma, prejudice and discrimination
- **Anticipated stigma**, where the service user expects rejection, which may of course change their behavior e.g. to hostility, leading to a self-fulfilling prophecy
- **Received stigma**, when the service user experiences discrimination, is rejected or devalued
- **Enacted stigma**, another term that refers to actual discrimination in practice.
Stigma impact.

- Hopelessness “Why Try?”
- Low self esteem
- Stigma Stress
- Late diagnosis Physical & Mental
  – Worse outcomes
- Limited lives
- Suicide?

Anticipated stigma inhibits the chance the individual will present for early diagnosis, leading to worse long term results.

Experienced stigma and discrimination leads to hopelessness, the individual feels ‘Why Try? They experience stress and low self-esteem.

Provider stigma and structural discrimination are another factor leading to late diagnosis and poor treatment of both physical & mental health problems in the stigmatized group, leading to worse treatment outcomes, and more interactions with the criminal justice system. The resulting victimization, social isolation, unemployment, poverty and homelessness lead to very limited lives for some long term mental health service users, and these are factors known to increase the risk of suicide.

Case History

Ruth was working long hours and overnight shifts away from home without her usual supports. Following her fathers’ sudden and unexpected death, and a run of sleepless nights, she became manic and was eventually detained on a section. Ruth recovered sufficiently to return to work, but soon became depressed and suicidal, resulting in another detention. She was told that due to the severity of her illness she would probably never hold down a job or have a long term relationship. Lonely, isolated and unable to work she moved back to live with her mother and began to come to church.

Over several years, with medication and learning, by recognizing early warning signs and psychological therapies from the mental health services, and with a loving supportive community through the church, Ruth’s mental health became more stable. She began to rebuild her life and relationships and came to a living and active faith. Ruth was able to take on small tasks and roles within church which started a positive feedback loop.

Ten years ago she got married, and now has two children, one of whom was born premature. Ruth coped with these changes and challenges without becoming ill. The children are now at school and Ruth has a part time office job and a full active social life, and helps others through the church. She has been off all psychiatric medication for 15 years. She credits the church community with getting her through her mental illness.

One of the challenges in thinking about Stigma and spirituality or religion, is being specific about the type of spirituality. You can’t simply say ‘Christians think’...Christianity for example, has multiple denominations.
There are variations between the different branches of the Christian family, not in the overall teaching but in the emphasis placed on different aspects. Some Christians, mostly from Pentecostal and Charismatic churches, teach that if you confess your sins, pray hard enough and really mean it then God will ALWAYS heal you. A Charismatic church community full of forty-year olds can get away with this theology for a few years, but as people age and die this challenges this theology. Some Christian groups believe that mental illnesses (along with addictions, homosexuality and several other phenomena) are caused by demon possession and will seek to cast out these demons.

In the Church of England and Roman Catholic churches each diocese has trained ‘deliverance ministers’ (new term for exorcists) and psychiatrists to advise on cases, and exorcisms are very rare. Similarly for Muslims there are a variety of attitudes towards mental illness largely driven by local culture and interpretations of Islam.
I recently spoke at a Muslim students’ conference and many of the issues were exactly the same as faced by committed Christians:

‘How can you be a committed, spiritual believer and still struggle with mental illness?’
‘If you pray you shouldn’t need to take medications too.’
‘Real Muslims don’t get depressed.’

Some Muslims think that mental illness can be caused by the presence of Djinn (spiritual beings, which are not human and not angels). Evil Djinn can take over a body, and can be driven out by prayer, fasting, rituals and beating, and it is permissible to beat the person severely because you are really only beating the Djinn!

For many service users, their religion helps them to cope with their mental health problems, through prayer and scripture reading, through individual pastoral support and through an accepting and supportive community, which gives them a valued social role. I think here of the young man with learning disabilities at my church who always collects the hymn books with a smile, and stacks them carefully. He enjoys doing this job, which earns him praise and gives him a role in the community. The severity of stigma in a particular community is largely determined by the perceived cause of mental illness.

If the cause is seen to be internal, irreversible and your own fault (e.g. laziness, weakness) there is more stigma than if the cause is seen as external and reversible (e.g. witchcraft). Stigma theorists initially thought that teaching about the biological and genetic causes of mental illness would lead to less discrimination, since a person can't be blamed for their biology. However this seems not to be the case since the irreversible nature of a genetic condition makes it more highly stigmatized.

We know that people with schizophrenia have better social outcomes in less industrialized countries and worse in highly capitalist and individualistic countries.\textsuperscript{8,9} It has been suggested that this is due to less stigma and discrimination in the developing countries. If we combine two sets of data we can see that this is unlikely to be the answer.

If we take the Inglehart–Welzel Cultural Map from the World Values Survey (WVS, 2000):

**Perceived Causes of MI**

| Spirit Possession: Christians, Muslims |
| Witchcraft & punishment: Zambia, Pakistan |
| Neglect of traditional rituals: Uganda |
| Weakness, laziness: Hispanic, Japan |
| Loss of Dusha: Russia |
| Neglect of Dharma: Bangalore |
| Bad Karma: India, China |
This shows the world’s countries separated on an axis of more or less traditional (i.e. religious) vs. secular. At one extreme, 98% of those interviewed in Indonesia affirm that ‘Religion is very important to me’ at the other end just 3% say this in China. Traditional values emphasize nationalism and religious conformism. People are generally obedient to authority and have a high regard for marriage. Secular-rational values emphasize the opposite of these points.

The other axis is survival vs self-expression values, which is closely linked to the economic status of individuals in those countries.

High scores on survival values predict that security is prioritized over individual liberties: outsiders are viewed with suspicion, few people are politically active, homosexuality is seen as unacceptable, and there is a weak sense of happiness. Self-expression values are the opposite. As countries develop and survival is more secure most travel diagonally towards top right. War brings uncertainty and risk of death, and so tends to push a country down and left.

The Stigma in Global Context- Mental Health Study is a vignette and questionnaire survey of stigma in 16 countries. The results are plotted to show levels of stigma in each country.
The intensity of discrimination against those with mental health difficulties is also related to ‘What matters most’ in that particular cultural group. For those of Chinese descent continuing the family line is of major importance and those who cannot establish healthy relationships and have children or who bring shame on the family are greatly discriminated against. In Ghana the valued role is supporting the community in practical ways and those who always need support are stigmatized. In the West, e.g. Germany, it is being economically productive that is most valued, and those who don’t have a job outside of the home are discriminated against.

How can we counter the effects of stigma and discrimination?

There are three main tactics: Contact, Education and Protest. The Time to Change campaign covers each of these areas and offers many resources for personal and local action.
Contact means ensuring that those with mental illness come into contact with those who haven’t yet got a diagnosis, either directly or indirectly through positive media coverage of mental health and recovery. Education is both providing facts about mental illness and also about the rights of those with mental illness. Protest includes emailing media outlets and shops that discriminate, as well as challenging those around us with use of language and more formal campaigns e.g. Time to Change.

There are online resources around Religion and Mental Health to which we can point our patients. Jewish association for Mental Illness advocates and provides services for Jewish people with mental health problems. 14

Different Christian churches have different projects. 15 ‘The mental health’ project is Roman Catholic, ‘Mind and Soul’ is Free Church, and ‘Mental Health Matters’ is Anglican. There are resources being developed for the Muslims community and mental health 16.

Stigma has come full circle with the reclaiming of tattooing and marking by those who have personal experience of mental illness. Project Semicolon 17 was started by Amy Bleuel who was an active member of her local church, motivated and sustained by her faith, in 2013, in response to her father’s suicide. People who have attempted or been close to suicide get a semi colon tattoo to show that they are happy to talk about mental illness.
About Project Semicolon, Amy Bleuel explains:
‘In literature, an author uses a semicolon to not end a sentence but to continue on. We see it as you are the author and your life is the sentence. You’re choosing to keep going.... Despite the wounds of a dark past, I was able to rise from the ashes, proving that the best is yet to come. When my life was filled with the pain of rejection, bullying, suicide, self-injury, addiction, abuse and even rape, I kept on fighting. I didn’t have a lot of people in my corner, but the ones I did have kept me going. In my 20 years of personally struggling with mental health, I experienced many stigmas associated with it. Through the pain came inspiration and a deeper love for others. God wants us to love one another despite the label we wear. I do pray my story inspires others. Please remember there is hope for a better tomorrow.’

But all anti-stigma effort is complex and difficult, and we know mental illness is a killer. Amy, who inspired so many to keep going, died by suicide age 31 years in March 2017, while I was preparing this presentation.18,19

We know what works to reduce stigma and we can all be involved - Contact, Education, Protest. Contact requires initially self-acceptance, and then for individuals to become visible by ‘coming out’ to friends, family, colleagues and faith communities as someone who has used mental health services. If we haven’t used services ourselves, we can support our friends and family who have done so, to acknowledge this as appropriate for them. As psychiatrists, we can undertake education about mental illness, particularly for police, healthcare workers, teachers, religious leaders as well as the general public.
We can all check our own attitudes, and speak up when we hear someone stigmatising those with mental illness. We can support each other to watch the media, complaining against stigmatising portrayals and giving compliments where mental illness is well handled.

Cancer was once heavily stigmatised and now people speak much more freely about it. One of the changes is that many forms of cancer are now treatable so that people recover. Similarly, we need to support political campaigns for better funding for mental illness research, care and treatment, and support early intervention to improve the illness course for those affected in order to bring mental health to parity of esteem with physical health.20

As the Royal College’s first anti-stigma campaign said: Mental Illness affects every family in the land, and we can all join Time to Change,21 and act locally, nationally and globally to challenge stigma and discrimination wherever we see it.
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Lived experience of stigma and recovery

Dr Jo Barber, service user

On 21st April this year I was privileged to speak at the conference ‘Silent Prejudice: Stigma, spirituality and mental health’, held by the Spirituality Special Interest Group at the Royal College of Psychiatrists. My talk was entitled ‘Lived Experience of Stigma and Recovery’ and it included description of all the different sorts of stigma I have experienced as a long term mental health service user over many years.

I once had the experience of being hospitalized for several years, and more recently have been supported on many occasions by the Home Treatment Crisis Team. As a qualified medical doctor and a religious person, I have been particularly vulnerable to stigma. I identified four distinct ways in which I have been stigmatized. The first, amongst any friends that I did have, was stigma against mental illness in general, especially when I received a diagnosis of schizophrenia. The second was concerning the fact that I was a doctor with a mental health problem. Some of the clinical staff in the hospital where I was a patient commented that I had a good job and must be intelligent and therefore should not have succumbed to a mental illness. The third experience of stigma occurred within the church I attended, where my religious problems were thought to indicate possession and I had deliverance ministry. Unfortunately, this was unsuccessful and I left the church feeling disgraced. The fourth experience was in the hospital, where it was assumed that my difficulties were purely the result of illness and I should have been cured by medication. Unfortunately, although medication was partially helpful, it was by no means a total cure. Again I felt blamed and I was confused by the conflicting messages I received from the ministers at the church and the hospital staff.

Spiritual care has helped me to overcome many of these difficulties. Spiritual care assumes a spiritual dimension to mental health problems and seeks to help people find positive meaning and purpose through their religious or spiritual experiences. It involves firstly making a trusting therapeutic relationship with the care provider so that a spiritual assessment can be made. Referral to the appropriate faith chaplain can be made if desired by the service user. In my talk I described the difficulties I had trusting anyone with the details of my experiences and how eventually I came to trust a particular psychiatrist who helped me faithfully over many years. He referred me to a Christian chaplain. The job of the chaplain is to use their expert discernment to disentangle religious experiences from symptoms of illness and help the person to address their difficulties in a way acceptable to them.

Crucially, spiritual care is a holistic intervention, validating and respecting peoples’ experiences without any stigma or judgement. For me personally, this was life changing. I now have rejected some of my misconceptions about religious doctrine, and have much better acceptance, understanding and control over my experiences. I have an active life, living on my own with my cat and doing some mental health research. Most importantly, I have found a church where I receive understanding and care. I no longer feel stigmatized for having mental health problems and I am very grateful to all the people who have helped me along the way. It is only when you feel accepted and valued by others that you can begin to accept and value yourself.

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Prejudice – can we live without it?

Dr Andrew Powell

I will start with a well-known Zen story:

The Zen master Hakuin was praised by his neighbours as living a pure life. A beautiful Japanese girl, whose parents owned a food store, lived nearby. Suddenly, without any warning, her parents discovered she was with child. She would not confess who the man was, but after much harassment at last named Hakuin. In great anger the parents went to the master. ‘Is that so?’ was all he would say. After the child was born it was brought to Hakuin. By this time he had lost his reputation, which did not trouble him, but he took very good care of the child. He obtained milk from his neighbours and everything else he needed.

A year later the girl-mother could stand it no longer and she told her parents the truth that the real father of the child was a young man who worked in the fish market. The mother and father of the girl at once went to Hakuin to ask forgiveness, to apologize at length, and to get the child back.

Hakuin was willing. In yielding the child, all he said was: ‘Is that so?’

How many of us could lose our reputation and good name and retain complete equanimity in the face of such undeserved prejudice?

Now for a story of my own:

One hot summer day in 1981, rioting broke out in the predominantly black neighbourhood of Brixton, London. My home was close by and from the garden I could see billowing smoke and flames. The air reverberated with the noise of breaking glass, screams and police sirens. On the radio, I heard that rioters were on the march and would be coming past my house. Immediately I rushed about looking for a weapon to defend my home and young family. I found an axe and waited inside the front door, prepared for the worst. As it happened, the rioters took a different route but this was a great lesson to me. I had seen myself as a tolerant, liberal-minded psychiatrist and within a few minutes, I had become capable of extreme violence.

It could be argued that defending one’s family is a natural instinct. Yet there was something else that I was forced to admit – the world had suddenly become a place of ‘us’ and ‘them’, us being the peaceable white home-owning professional class and them being the angry and dispossessed black community living a stone’s throw away. Far from retaining equanimity, my prejudice had run wild.
As widely used, prejudice means a preconceived opinion that is not based either on reason or actual experience - a negative prejudgment about a group or its members.¹ It is more than just a statement of opinion or belief, for it is imbued with feelings such as contempt or even loathing. In its extreme form, it can result in sheer indifference to the fate of one’s fellow human being, for instance, as shown by the treatment of the Jews and others in Hitler’s death camps. Indifference is possible when a person is no longer seen as a fellow human being. Such dehumanisation is evident today in what is known as ‘the war against terror’, in which neither side views the other as human and remotely deserving of compassion.

In trying to account for prejudice, social scientists have looked at how we make judgments. Gordon Allport pointed out that ‘the human mind must think with the aid of categories...Once formed, categories are the basis for normal prejudgment. We cannot possibly avoid this process. Orderly living depends upon it’.²

While categories are seeming clear cut, they are in fact only approximations.³ There is a continuum between good and evil, summer and winter flow one into the other and the male and female genders too, are blurred these days. Categories may help us read the map but the territory is another matter.

In the case of prejudice, categorising turns into categorical thinking that distorts perception. Differences between the in-group and out-group are exaggerated while intra-group heterogeneity is glossed over. This leads to stereotyping. Children as young as 2½ years of age will stereotype, as shown by one study of anti-Arab prejudice in Israeli infants.⁴ Unfortunately, such stereotypes are self-perpetuating unless vigorously countered.

Here is a short list of the devastating effects of prejudice: racism including white supremacism and slavery, anti-Semitism and Islamophobia, religious war, genocide and so-called ‘ethnic cleansing’, stereotyping and stigmatization, sexism and gender oppression, and ageism.⁵

I now want to turn to early human history in suggesting that prejudice has been around a very long time.

The first advanced hominid was Homo neanderthalensis, a skilled tool maker who provided care and shelter for his family group. Neanderthals lived a nomadic life, with ample territory for hunting across Europe and Russia and it is thought internecine feuding was rare – the only

¹ The word prejudice first appears in the English language in the 14th Century CE. Its etymology is from the Latin prae meaning ‘in advance’, and judicium meaning ‘judgment’. There is an assumption also of unfairness, the Latin praejudicium meaning ‘injustice’.


⁵ Scientism asserts that only the material world is ‘real’ and atheism similarly denies any supre-
ordinate reality. Both presume to hold a superior claim on the truth, while failing to recognise that their fundamental status is that of belief systems. The Spirituality and Psychiatry Special Interest Group, while valuing science, rejects scientism. Similarly, the group is concerned to explore the meaning and purpose of existence from both secular and spiritual perspectives (see www.rcpsych.ac.uk/spirit).
enemy was the cold climate. Then Homo sapiens came out of Africa around 195,000 years ago. Migrating across Asia and Europe, Homo sapiens overlapped with the Neanderthals and we know some interbreeding took place. However, about 40,000 years ago, Neanderthals became extinct. Why this happened remains something of a mystery but at the very least, Homo sapiens had the advantage of a larynx better suited to the development of speech and seems to have outstripped the Neanderthal in cultural complexity and the capacity for symbolisation.

The Neolithic age, around 12,000 years ago, marked the world-wide migration of Homo sapiens. Human society now took a giant step forwards with the development of agriculture, husbandry, property, advanced tool making and a progressively structured, hierarchical social order. It is very likely that this also marks the era when endemic conflict among humans first arose, since when it has never stopped.

The advancing complexity of human society and the civilization that it conferred is testimony to the accomplishments of the human ego in driving forward the human species’ mastery over the animal kingdom and the natural world. However, all has not gone well subsequently with the balance of Nature.

In the Neolithic era, Homo sapiens numbered around one million. 200 years ago the world population had increased to one billion. By 1960 there were three billion and we now number 7.5 billion. Countless animal species have been eliminated and we also ferociously attack our own kind. At the same time, the destruction inflicted on the planet – on its atmosphere, hydrosphere, cryosphere, geosphere and biosphere – looks set to result in a global catastrophe in our children’s lifetime if not our own.

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6 1-4% of Neanderthal genomic material is present in non-African people today.
7 There may also have been genetic differences of temperament comparable to the two species of great apes living today, chimpanzees and bonobos. In contrast to the chimpanzee, the bonobo is exceptionally peace loving and as a result bonobos have become an endangered species.
8 In the story of Creation, God blesses humankind with these words: ‘Be fruitful and increase in number; fill the earth and subdue it. Rule over the fish in the sea and the birds in the sky and over every living creature that moves on the ground’ (Genesis 1:28, The Holy Bible. NIV.) Whether or not we take the story of creation literally, this was an extraordinarily prescient depiction of what later was to come but not, unfortunately, in the benign form of stewardship intended. Human beings have instead appropriated the earth for their own purposes, showing none of the forethought and humility that would have been needed to ensure that the species remained in balance and harmony with the abundance of Creation.
9 Since 1900, the animal kingdom has suffered around 1000 times the natural background extinction rate, and is known as the sixth mass extinction in Earth’s history.
10 See Calhoun, J. B. (1962) Population Density and Social Pathology. Scientific American 206:139-148, for a summary of Calhoun’s research with rats, showing how overcrowding causes uncontrollable aggression that can result in decimation of the animal population.
11 Estimates put death from violence, oppression and war in the 20th century at between 150 - 200 million - more than in the entire history of the planet to date.
Surely evolution would not lead us down a blind alley? Even the ‘selfish gene’ would not embrace its own demise. Is there anything psychiatry might have to say about the apparently suicidal behaviour of our species?

There is a simple medical analogy - that of autoimmune disease. We depend for our survival on antibodies that develop in response to an otherwise lethal array of antigens, viral, bacterial and chemical. But when the immune system goes into overdrive and attacks the self, the consequences can be dire.

So it is with the mechanisms of defence that determine how we respond psychologically to threat. In earlier human civilisation, they ensured group survival, yet today they threaten us with destruction. We can understand this better by taking a look at the propensities of the human ego.

The ego is an indispensable function of the psyche. It is the means by which a child becomes conscious of its identity – indeed, that it exists as a ‘self’. For this to happen, the ego first enables the child to learn the difference between ‘me’ and ‘not me’. The distinction between awareness of self and other gives each of us a mind of our own, a unique blend of thoughts and feelings, with a personal narrative that weaves us into a timeline of past, present and future.

The ego drives the child to explore the world with curiosity and a sense of adventure. As socializing grows, there is the discovery of group kinship and the cultural richness of all that follows. However, what I want to highlight here is that self-awareness greatly complicates what it means to be a social animal. I will illustrate briefly with reference to the model of the ‘triune brain’, put forward by Paul MacLean over 50 years ago.13

The so-called ‘reptilian’ brain includes the basal ganglia and structures derived from the floor of the forebrain. Maclean argued that it is responsible for behaviours involved in aggression, dominance and territoriality.14 The ‘paleomammalian’ brain comprises the nuclei of the limbic system, which Maclean saw as governing motivation and emotion involved in feeding, reproductive and parental behaviour. Last but not least comes the ‘neomammalian’ brain or cerebral neocortex, the most recent stage in evolution, conferring the ability for language, symbolisation, abstraction, planning, perception and, crucially, empathy.

When we humans feel safe from threat and are sustained by loving relationships, there is harmonious integration of these levels of function, resulting in adaptive and mature human behaviour. Nevertheless, this is a fragile balance and stress unmaskes more primitive behaviour.

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Let me come back to my story of the Brixton riots. As my anxiety level rocketed, my limbic brain went into overdrive, emotion flooded my rational self and the fight/flight mode kicked in - at its most extreme, either to kill or be killed.¹⁵

When I had calmed down, however, my neocortex asserted itself and the values inculcated during my upbringing came to the rescue; the wave of my prejudice subsided as quickly as it had arisen. At the same time, I could see that a different personal history may have left me with my prejudice powerfully reinforced; the point being that past experiences shape our response to threats whether real or imagined, and it is belief, not fact, that wins the day. It has been said that if you give a person a gun, that person may kill dozens, but if you give a person an ideology, that person may kill countless thousands.

Psychoanalysis has had something very useful to say about ego defences. Children who live in fear of abandonment cannot risk getting angry with their parents or caregivers. Anger is associated with vulnerability and so must be got rid of. If this can be achieved, then the threat is gone both outwardly (the needed caregiver will not retaliate) and inwardly (the ego is now free from contamination with anger, and so can hope to be lovable). However, the split-off anger needs to go somewhere, hence it gets projected into a suitably vulnerable ‘other’ where it can be treated with contempt, attacked and (in accordance with magical thinking) destroyed.¹⁶ This dynamic of splitting and projection characterises scapegoating and abusive relationships in particular, but also applies to human society more widely, as I shall be describing.

Carl Jung, who was well aware of the destructive side of human nature, made a deep study of the archetypes, of the persona that we show to the world and the shadow that when made conscious, compels us to recognise our imperfection and fallibility.¹⁷ Jung’s concern was to make the shadow conscious, not only to confront the ego with its conceit but also to disarm the shadow of its destructive power by containing it and valuing it as part of the self. The aim of individuation, according to Jung, is to become whole, for only with wholeness can there truly be healing.¹⁸

Both psychoanalysis and Jungian psychology envisage health as freedom from distortion of reality due to unconscious projections. For Jung, however, this is a matter for the soul, as clearly revealed posthumously in his Red Book.¹⁹

I earlier drew attention to the emerging social complexity that defined the onset of the Neolithic era, which brings me to the part played by defence mechanisms in the social group. In common with much of the animal kingdom, human survival has depended on developing a group culture that allows for differentiation of labour, better provision for care of the young,

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¹⁵ In warfare, this mode of function is sanctioned and medals are awarded, although more usually we are conditioned to resist such impulses.
¹⁸ The words wholeness and healing share the same linguistic root.
¹⁹ Jung’s private reflections, written between 1915 – 1930 in the Red Book (or Liber Novus) were finally made public in 2009 and were published in 2012 by W. W. Norton and Co.
a milieu in which bonding of kith and kin can be established and more effective protection of the species when under threat. As agrarian communities enlarged, this meant that control moved from the family to centres of influence and power. Politics was born in the form of fiefdoms, nepotism and, of course, taxes.

Sigmund Freud has described how the group leader carries the ego-ideal for the group\(^{20}\). At best this is a force for good but at worst, it renders the group susceptible to manipulation\(^{21}\) - as we see in the politics of extreme nationalism, and also religious proselytism. Such movements are generally accompanied by suppression of individual freedoms in favour of a rigid and unquestioned group norm\(^{22}\).

Throughout history, the state, the military,\(^{23}\) and religion, have shaped the culture of the developed world. When there has been serious ideological conflict, their effectiveness as institutions of governance is collectively strengthened by splitting and projection - it is well known that a nation is never more united than when at war. All war, whether political, territorial, ethnic or religious, is centred on an ego-ideal that justifies the need to fight, either to proselytise (the truth must be imposed if resisted), to defend against incursion (the right of sovereignty), to regain what was once taken (there is a historical wrong to be righted), to claim territory (for assets that ‘justly’ can be appropriated), or to unify the group (when in danger of fragmenting). This last manoeuvre is a device by means of which a leadership in danger of being overthrown will create an enemy and thereby preserve its power.\(^{24}\)

I have alluded to the broad sweep of nation states but like a fractal that repeats over and over, we find the same mechanisms at work in sectarian disputes, local communities where there is ethnic and cultural division and in troubled families,\(^{25}\) for war is, more than anything, a state of mind.

I am now ready to opine on the nature of prejudice. Prejudice is a persistent derogatory attitude based on a separative ego-mentality that dissociates self from other; it is rooted in


\(^{21}\) As described in Aldous Huxley’s 1932 novel Brave New World (Vintage Classics, 2007), which portrayed a benign but soulless tyranny.

\(^{22}\) ‘Conspiracy theory’ is based on the supposition that while freedom of expression is permitted so that people can feel they have a voice, the real power-brokering continues hidden from democratic scrutiny.

\(^{23}\) Weapons manufacturing is now in excess of 400 billion US dollars annually. See SIPRI Yearbook 2016. OUP, in conjunction with Stockholm International Peace Research Institute.

\(^{24}\) For a powerful portrayal of such a dystopia, see Orwell, G. (1949) Nineteen Eighty-Four. Penguin Classics.

\(^{25}\) Individual patients may come with a psychiatric label because they are unwittingly carrying the split-off projections of their partner or family, in which case attempting to treat the patient in isolation only serves to reinforce pre-existing dynamics.
fear although often masked by compensatory grandiosity and it seeks to find fault with the alien ‘other’ 26 rather than engage in honest self-examination.27

When a group holds a prejudice, cohesion is strengthened but at the cost of its humanity. Splitting and projection blunt the capacity of the psyche to see the whole picture. Instead, self-esteem is pathologically reinforced by arrogance and intolerance of difference. The ego would rather that we all sang from the same hymn sheet; to be more exact, ‘my’ hymn sheet – for the words ‘me’ and ‘mine’ are the most important words in its vocabulary.

Because of the ego’s intolerance of ‘otherness’, we are attracted to similarities of educational attainment, political affiliation, religious beliefs, social habits, sexual orientation and much more besides. Yet what we find in today’s multicultural world is a bewildering array of differences – of skin colour, dress, language, religion and social attitudes. The ego, insecure and on the defensive, is quick to offend and equally quick to take offence, in consequence spending a good deal of its time on the brink of outrage.

What is to be done? Rather than get caught up in the ego’s perturbations, we can remind ourselves of the indivisible source from which both self and other, subject and object, originate. This fundamental unity of being is woven into all of life, not least ourselves. Nevertheless, since its manifestation is spiritual, to find it we have to look with other eyes28. On the mundane level, personal differences will always be visible since we are uniquely made. Yet when we go beyond the appearance of things, we discover the unbroken wholeness from which all life arises.29,30 It follows that self and other are as inseparable as two sides of one coin. This is how the soul sees it. Undeterred by the prejudices of the ego, the soul knows better and persists in loving indiscriminately and unconditionally. Where fear is divisive, love is unitive; where fear is separation, love is connection; where fear is constraint, love is freedom; where fear says ‘mine’, love says ‘ours’.

Allport, in the language of the social sciences, advocates the following approach to prejudice:

‘Prejudice…may be reduced by equal status contact between majority and minority groups in the pursuit of common goals. The effect is greatly enhanced if this contact is sanctioned by institutional supports…and provided it is of a sort that leads to the

26 Hence the saying of Jesus in defence of the woman accused of adultery: ‘Let any one of you who is without sin be the first to throw a stone’. John 8:7. The Holy Bible, NIV.
27 In otherwise decent people, prejudice is revealed by the absence of empathy when ordinarily it might have been expected.
29 In this regard, the so-called ‘developed world’ could learn much from the spirituality of indigenous cultures that have always held sacred the unity of all life.
30 The physicist David Bohm stated: ‘Ultimately, the entire universe (with all its particles, including those constituting human beings, their laboratories, observing instruments, etc.) has to be understood as a single undivided whole...’ In Bohm, D. (1980) Wholeness and the Implicate Order, p.174. Routledge.
perception of common interests and common humanity between members of the two groups’\textsuperscript{31}.

This all makes good sense, yet it does not move the heart. Instead, I will end with a story told by the Aikido master Terry Dobson. If you already know it, I hope you will agree that like all good parables, it is worth hearing a second time.\textsuperscript{32}

‘A turning point came in my life one day on a train in the suburbs of Tokyo. It was comparatively empty—a few housewives with their kids in tow, some old folks out shopping. At one station the doors opened and a man bellowing at the top of his lungs shattered the quiet afternoon, yelling violent, obscene curses, staggered into our carriage. He was big, drunk and dirty. His hair was crusted with filth. Screaming, he swung at the first person he saw, a woman holding a baby. The blow glanced off her shoulder, sending her spinning into the laps of an elderly couple. It was a miracle that the baby was unharmed.

The passengers were frozen with fear. I stood up. I was young and I’d been putting in a solid eight hours of Aikido training every day for the past three years. My teacher, the founder of Aikido, always taught us that the art was devoted to peace. In my heart of hearts, however, I was dying to be a hero. ‘This is it!’ I said to myself as I got to my feet. ‘This animal is drunk and mean and violent. People are in danger. If I don’t do something fast, somebody will probably get hurt.’

Seeing me stand up, the drunk saw a chance to focus his rage. I wanted him mad because the madder he got, the more certain my victory. I blew him a sneering, insolent kiss. It hit him like a slap in the face. He gathered himself for a rush at me.

A split-second before he moved, someone shouted ‘Hey!’ It was ear splitting. I remember being hit by the strangely joyous, lilting quality of it. ‘Hey!’ We both stared down at a little old Japanese man. He must have been well into his seventies, sitting there immaculate in his kimono and hakama. He took no notice of me, but beamed delightedly at the drunk, as though he had a most important, most welcome secret to share. ‘Come here,’ the old man said, ‘Come here and talk with me.’ He waved his hand lightly. ‘Talk to you,’ the drunk roared, ‘Why the hell should I talk to you? The old man continued to beam at him without a trace of fear or resentment. ‘What’ya been drinking?’ he asked lightly, his eyes sparkling with interest. ‘I been drinking sake and it’s none of your goddam business’. ‘Oh, that’s wonderful,’ the old man said with delight, I love sake too. Every night, me and my wife (she’s 76, you know), we warm up a little bottle of sake and take it out into the garden, and we sit on the old wooden bench and watch the sun go down, and we look to see how our persimmon tree is doing. My grandfather planted that tree, you know, and we worry about whether it will recover from those ice-storms we had last winter. Persimmons do not do well after


ice-storms, although I must say that ours has done rather better than I expected, especially when you consider the poor quality of the soil. Still, it most gratifying to watch when we take our sake and go out to enjoy the evening—even when it rains!’ He looked up at the drunk, eyes twinkling, happy to share his delightful information.

As he struggled to follow the old man’s conversation, the drunk’s face began to soften. His fists slowly unclenched. ‘Yeah,’ he said slowly, ‘I love persimmons, too... His voice trailed off. ‘Yes’, said the old man, smiling, ‘and I’m sure you have a wonderful wife.’

‘No,’ replied the drunk, ‘my wife died.’ He hung his head. Very gently, swaying with the motion of the train, the big man began to sob. ‘I don’t got no wife, I don’t got no home, I don’t got no job, I don’t got no money, I don’t got nowhere to go. I’m so ashamed of myself.’ Tears rolled down his cheeks and a spasm of pure despair rippled through his body. Just then, the train arrived at my stop. As the doors opened I heard the old man cluck sympathetically. ‘My, My,’ he said, ‘that is a very difficult predicament, indeed. Sit down here and tell me about it.’

I turned my head for one last look. The drunk was sprawled on the seat, his head in the old man’s lap. The old man was softly stroking the filthy, matted head.

As the train pulled away, I sat down on a bench. What I had wanted to do with muscle and meanness had been accomplished with a few kind words. I had just seen Aikido tried in combat, and the essence of it was love’.

Returning to the title of this paper ‘Prejudice – can we live without it?’ my answer is ‘Yes, we must, if there is to be a future for humanity’. 
Anti-Semitism and its mental health effects

Professor Kate Miriam Loewenthal

Abstract

This paper looks at definitions and examples of anti-Semitism, examples of victim’s reactions to anti-Semitism including some ways of coping and their effects, and describes the Holocaust and its effects, including the KZ syndrome (concentration camp syndrome) and its effects on descendants.

Definitions

A range of definitions of anti-Semitism has been offered, all converging on the concepts of prejudice, stereotyping and hostility towards Jews. For example:

- ‘Anti-Semitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of anti-Semitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities.’ (International Holocaust Remembrance Alliance (IHRA) May 2016

- The government is to formally adopt a definition of what constitutes anti-Semitism (above), which includes over-sweeping condemnation of Israel (www.businessinsider.com/britain-new-anti-Semitism-definition-2016-12)

- ‘The belief or behaviour hostile toward Jews just because they are Jewish. It may take the form of religious teachings that proclaim the inferiority of Jews, for instance, or political efforts to isolate, oppress, or otherwise injure them. It may also include prejudiced or stereotyped views about Jews’. (ADL Anti-Defamation League, accessed March 2017)


Is anti-Semitism on the rise? The general conclusion is affirmative, but the evidence base could be stronger, and actual reporting of anti-Semitic incidents is very much lower than the occurrence of such incidents. I, for example, have experienced a number of incidents but have never regarded any as sufficiently significant to report. Examples of recent media reporting include:

- The Guardian 2 Feb 2017: ‘The number of anti-Semitic incidents in the UK rose by more than a third to record levels in 2016, according to data released by the Community Security Trust... The CST, which monitors anti-Semitism and provides security to Jewish communities, recorded 1,309 incidents of anti-Jewish hate last year, compared with 960 in 2015, a rise of 36%. The previous record number of incidents was in 2014, when 1,182 were recorded... The CST’s chief executive, David Delew, said: ‘While Jewish life in this country remains overwhelmingly positive, this heightened level of anti-Semitism is deeply worrying and appears to be getting worse. Worst of all is that, for
various reasons, some people clearly feel more confident to express their anti-Semitism publicly than they did in the past.’

- **The Independent** 25 Jan 2017: ‘Jewish people in Europe are suffering from a virulent wave of anti-Semitism amid a rise in dangerous political extremism that is threatening to divide societies, a senior leader of the community will warn in a meeting with the Pope on International Holocaust Remembrance Day’.

- **The Jerusalem Post** 23 Jan 2017: Editorial headed: The shocking rise of anti-Semitism in the US. ‘There are no easy answers to anti-Semitism, humanity’s oldest hatred. The recent US presidential campaign was a major catalyst for the dissemination of hate speech and enabled the voices of marginal groups to reach far beyond their own communities... From August 2015, to July 2016, the ADL found 2.6 million tweets that included anti-Semitic language, as news coverage of the presidential campaign increased. Researchers looked more closely at attacks on the Twitter accounts of some 50,000 journalists and found almost 20,000 anti-Semitic tweets directed at them, with almost 70% of the invective coming from 1,600 accounts... Part of the problem has to do with the unwillingness of Twitter and other platforms to block the accounts of people who disseminate hate speech. These platforms’ terms of service outlaw hateful conduct. But response to complaints is often slow’.

**Examples of anti-Semitism**

Daubed slogans:

Desecration of Jewish cemeteries:
Anti-Zionism, seen by many as anti-Semitism with a politically-correct whitewash:

Re-runs of long-standing anti-Semitic stereotypes:

Here are some examples described by the NUS (National Union of Students) president Megan Dunn (Huffington Post 3 Nov 2016)

...a poster saying ‘Hitler was right’ on campus, and people tweeting...to say that Jewish people should be ‘popped back in the oven’...graphics ...which call Jews ‘Zionist racist scum’ and suggests the Holocaust was ‘invented’. The people who write blogs that 9/11 was an ‘insurance scam’ by ‘a secret Jewish network’. Those who write on Facebook that ‘Adolf and Co should have finished the job properly’, pose questions like ‘why stop at 6 million?’ and the artists who depict Jews as thieves with big noses.

More examples from my direct experience in contemporary London:

• Taunts of ‘dirty Jews’, ‘filthy Jews’, ‘Jewbugs’
• Some violence – children and adults knocked off bicycles, attacked by groups sometimes with dog/s
• A housewife with young children described how they were woken by a shouting group of youths calling for Jews to go back into the gas ovens (sic). The housewife and her children had prepared water for the morning ritual washing of hands, and when they threw this water over the youths, they ran off
• A civil servant was made aware that his failure to gain promotion was the result of his refusal to work on Saturdays (on religious grounds): the line manager responsible was alleged to be hostile and anti-Semitic, but careful to allow no written evidence of discrimination
• Race relations in London are (with relatively infrequent exceptions such as those above) generally amicable and most people do not feel markedly threatened. Many women would not walk alone at night but this is a widespread precaution in most or all cities regardless of anti-Semitism.

In spite of legislation in many countries intended to protect minority groups and to promote harmonious race relations, anti-Semitism has not disappeared.

Effects of anti-Semitism

The remainder of this paper looks at the effects of anti-Semitism: contemporary reports of experiencing anti-Semitism, and the feelings evoked, also social-psychological research, and at psychiatric research particularly directed at the effects of the Holocaust.

Here are some examples from an examination of the effects of hate speech using real-life examples (of such speech):¹


‘I don’t give a damn what you say about me, you bagel-eating, hook-nose, lox-eating . . . Jew’.

‘To the ‘white Jews’ in the audience, I say: It’s gonna be a rough ride, buddy . . . . Buckle your seat belts . . . because I didn’t come to pin the tail on the donkey, I came to pin the tail on the honkey’.

‘You’re Jewish? Show me your horns, kosher boy’.

A content analysis of the accounts of how Jews felt when exposed to such speech produced the following patterns: (a) short and long-term consequences mirrored a three-stage sequence found within other traumatic experiences; (b) respondents described the motives of perpetrators as enduring, not situational; (c) the most common response strategies were passive; and (d) 55% of Jewish participants sought support.

Examples of reported effects:

‘Such comments shock, daze, sicken and anger me, putting me in a bad mood for a few days.’

‘I think any type of verbal attack has some type of lasting effect on my self-esteem and psyche.’

‘Less willing to disclose my identity in the future with strangers.’

Although:

‘I had already been made to feel proud of who I was so the words bounced off of me’.

* See BBC Channel 4 news items: https://youtu.be/sZHkfOlvCKM
A 1952 report by the Consultative Council of Jewish Organisations to UNESCO concluded that anti-Semitism caused (among pre-adult victims): Humiliation, anxiety, violence, persecution beliefs

A 2017 collection of reports* by Jewish students in the USA included:

‘...some kid stood up and shouted, ‘Mein Kampf!’ I was uncomfortable at first, but I thought it was a one-time outburst. His friends’ giggling and half-hearted ‘stop its’ seemed to keep him going, making my skin crawl, and I knew I had to say something. ‘Hi, could you stop’ I asked. ‘No. I’m not doing anything wrong.’ His friends started laughing and mumbled comments about the first amendment. ‘I’m Jewish and I find that really offensive.’ He looked at me and snickered, ‘You’re Jewish? Your nose is so normal. You don’t even look Jewish.’ ‘No one in the lounge said anything.’

‘I was sitting in a study lounge with a group of my sorority sisters. As I was packing up to leave, I noticed a Swastika carved into the table under my textbook. My friend called the RA on duty immediately, she warned that Public Safety won’t do anything unless someone was ‘really offended.’ We scoffed and naively told her that everyone should be offended, but... she was right. The first thing the public safety guy asked when he got there was whether anyone ‘really cared.’

A 2010 survey of Jewish students in California found them to feel ‘physically unsafe, emotionally and intellectually harassed and intimidated by peers and professors, isolated from their fellow students, and unfairly treated by faculty and administrators’. Their concerns are not felt to be taken as seriously as those of other minorities. ‘80% of all respondents expressed the belief that events, exhibits and campaigns that demonize Israel could incite violence against Jewish students on their campus; while several reported that it already had’.

This scattered material indicates consistently that the experience of anti-Semitism is unpleasant, and suggests that anti-Semitism is often downplayed both by Jews and bystanders.

Responses to anti-Semitism

As well as experiencing unpleasant feelings, elaborate social psychological experimentation has demonstrated a wide range of coping strategies, and has emphasised the influence of responses to anti-Semitism on the further behaviour of the persecutor/s.

Dion and colleagues2 implemented such an interactional approach to the study of impact of prejudice studied the impact of perceived prejudice upon stereotypic self-evaluations, self-esteem, and affect. They thought it important to study dynamic interactional processes, as for example in Bettelheim’s hypothesis that responses to prejudice may heighten prejudice. Victim groups studied were Jews, blacks, Chinese and women.

Effects considered were often complex: for example defensive self-presentation may be used to distinguish the self from the perceived stereotype of Jews, but this may exacerbate prejudice. For instance some work 3 has shown that counter-stereotypic self-presentation by

* See http://www.amchainitiative.org/effects-of-anti-Semitic-activity-on-jewish-students
minority group members has led to more negative evaluation by majority group members, than self-presentation which accords with stereotypes.

In another study Jews who perceived their failure at a task as the result of anti-Semitism experienced aggression, sadness, anxiety and egotism (compared to those whose failure was not perceived to be the result of anti-Semitism). Other negative feelings in response were not experienced (e.g. lack of control).

Much subsequent work has followed the transactional approach\(^4\).

Lowered self-esteem is not necessarily a consequence of prejudice and stigmatisation. Effects are mediated by many factors including threats to personal identity, clarity of prejudices cues in the situation, in-group identification, dispositional optimism, endorsement of legitimising ideologies, and group status.

So, possible responses to anti-Semitism can be affected by personal and situational factors. And it is important to appreciate that these responses can in turn affect the behaviour of persecutors.

The Holocaust and its effects.

We now turn to the Holocaust, one of many horrific episodes in human history in which the energies of a nation have been directed towards the elimination of specific ethnicities and other groups of people. The Holocaust period is normally dated 1933-1945. In 1933 Hitler became Chancellor of Germany and began to vigorously implement Nazi racist policies. Initially these policies were directed to rendering Germany free of Jews. The final solution was formalised in 1942 at the Wannsee conference in which formal plans were made to kill all Jews. The number of Jews killed in the Holocaust is normally estimated at about six million, and many others were also killed by the Nazi regime - dissenters, gypsies and disabled. The Nazi regime collapsed with Germany's 1945 defeat in World War 2, though Nazism is still currently active worldwide and associated with the dissemination of anti-Semitic beliefs.

These photographs depict aspects of the starvation and other horrors endured in the Nazi concentration camps to which many Jews were deported and in which most deportees lost their lives. Millions were slaughtered, and those in concentration camps suffered torture, constant stress, slave labour, and starvation, all inflicted as a result of anti-Semitism. The severity of the traumata suffered by the tiny minority of those who survived the Nazi concentration camps has caused commentators to remark repeatedly on the difficulty of understanding the nature of the concentration camp experience. One interviewer is said to have asked a survivor whether inmates of the concentration camps were provided with bedside lamps, illustrative of the huge gaps in communication and understanding, in which others failed to reach any realistic appreciation of the conditions.
Exposure to unimaginable extremes of human cruelty is said to involve 3 aspects: 5

1) ‘Entering into the hell of the camp was a shock beyond the normal stresses of human life. All authors writing on concentration camp experience emphasise appearance of the first reaction to imprisonment, which often ended with death’.

2) Adaptation involved a state of psychological numbness/anaesthesia. It is widely agreed that the term ‘concentration camp autism’ is appropriate.

3) ‘Psychophysical unity’: the prisoner had to find, in the hell of the camp, his/her ‘angel’, a person or a group of people who still approached him/her in a human way, ‘a true heaven in the true hell of the camp’. Bruno Bettelheim and Victor Frankl and others observed the importance of religious faith or other ideological commitment or purpose, and there are by now a number of published accounts particularly by religious publishers of the beneficial experience of such faith and purpose. However, most did not survive and most survivors were permanently damaged.

Examination of camp survivors led to the coining of the term ‘KZ syndrome’, with disputes about whether this should become a diagnostic category in its own right (KZ is from the German term Konzentrationslager).

Some symptoms did not appear until 10 or more years after release, making causality difficult to infer. KZ syndrome included a mixture of PTSD and other psychiatric symptoms, plus physical symptoms resulting from the severe physical hardships of the camps: ‘premature coronary arteriosclerosis, brain arteriosclerosis, pulmonary tuberculosis, chronic digestive tract diseases, arthritis, precocious involution, epilepsy, as well as anxiety-depressive syndromes and alcoholism’. 5 Survivor guilt is also often reported.

Recent studies of Holocaust survivors and their descendants have varied in the nature and reliability of their methodology, but much of the work is of at least acceptable standard. Those examined include concentration camp survivors, those hidden (terrifying conditions) and those who experienced life in Nazi-occupied countries but escaped. Such studies suggest the persistence of anxiety-depressive syndromes and sleep disturbances, PTSD and susceptibility to further stress and (possibly) cancer. 6 Some commentators mention mixed effects due to resilience.

A 30-year follow-up of camp survivors 7 confirmed the chronic and progressive nature of the KZ syndrome (involving comorbidity of physical and psychological symptoms). The majority of those surviving 30 years (78%) showed KZ syndrome, with number and severity of symptoms having increased over the years.

Holocaust studies indicate the extraordinary nature of the effects of prolonged ultra-severe hardship on the few who survived, and offer useful pointers to those working with survivors of comparably harsh and prolonged horrors. Of particular importance are the following features: the comorbidity of physical and psychological symptoms, the prolonged (in most
cases lifelong) nature of the condition, the widespread observation of deterioration over the years, and finally, the suggestion that descendants are at risk. I turn to this point now.

**Children of survivors**

There have been widespread claims that the mental health effects of the Holocaust extend to the children of survivors, possibly further.

Psychotherapists reported characteristic profiles of the descendants of survivors, but much research failed to show differences in psychopathology between survivor offspring and comparison groups. For example a systematic review\(^6\) concluded that there is insufficient evidence of reliable differences between the children of Holocaust survivors and comparison groups.

Another systematic review\(^8\) reached a similar conclusion for nonclinical samples, but also showed that among *clinical groups*, survivor offspring presented a psychological profile which included

- Predisposition to PTSD
- Difficulties in individuation-separation
- Vulnerability when coping under stress; sometimes (contradictorily) resilience.

Another review\(^9\) of work on both Holocaust and their descendants, as well as survivors of other ultra-severe hardships showed that descendants of Holocaust survivors have altered stress hormones – notably lower levels of cortisol especially if the mother suffered from PTSD. Some work shows effects of grandparent stress, particularly underfeeding, on grandchildren.

The Holocaust is unfortunately not the only episode of severe anti-Semitic persecution, and sadly there are episodes of severe persecution of groups other than Jews. But the study of the effects of the Holocaust has been a factor stimulating wider study of the effects of severe persecution, and hopefully a factor stimulating efforts to diminish such persecution worldwide.

**Conclusions**

Anti-Semitism, nowadays often conjoined with anti-Israel campaigning, is observed to be on the rise.

Some contemporary studies have described the reported feelings of Jews exposed to this, but work has been limited.

Experimental social psychological work indicates that reactions to anti-Semitism (and other forms of racism and prejudice) vary. There are complex transactional effects i.e. anti-Semitism is affected by the responses to anti-Semitism.

Work on Holocaust survivors - which includes much respectable epidemiological work - indicates the long-term duration of the effects of severe anti-Semitic persecution, progressive increase in severity and number of symptoms over the years, and possible effects on descendants.
References


Catholic and Gay - a Stigma?

Mgr. Keith Barltrop

I welcome this opportunity at the Royal College of Psychiatrists to consider the situation of LGBT people\(^1\), especially LGBT Catholics, through the lens of ‘Stigma’. My presentation should not be seen as arguing for a particular theological position, but as an exploration of certain themes common to pastoral care and psychiatry suggested by this topic.

An individual may suffer in various ways from the negative behaviour of others, through bullying or abuse, for example, but when we talk about stigma, we are referring to a more generic rejection, not just of an individual, but of all persons belonging to a particular group, on the basis of their race, beliefs, sexual orientation or some other factor, a rejection which makes it hard for them to build a robust sense of personal identity and self-worth.

The question of stigma is made even more complex today by the heterogeneous nature of many Western societies. In a traditional, homogeneous society, it is obvious which groups risk being stigmatised: those who do not fit into the dominant belief system or social group; Jews and atheists, certainly, Protestants or Catholics, depending on the nature of the society, and some others. But in a society like ours, stigma may apply in a fluid way to a variety of groups, depending on who is regarded as the dominant social group: in liberal circles, for example, being LGBT is quite acceptable, whereas being Catholic, or at least a certain kind of Catholic, carries a stigma as belonging to an outdated, superstitious and harmful body. In some religious circles, on the other hand, being gay is precisely what is stigmatised.

Being an LGBT Catholic therefore subjects a person to the risk of a double stigma in which one may feel threatened in his or her identity both as a Catholic and a gay person, a tension which can be too much for some to sustain. Since being gay is not something a person chooses, but religious belief is, it is active belonging to the Catholic Church that will usually be jettisoned in such cases.

In passing, we may note one interesting context in which this tension makes itself felt: the participation in Pride Marches by some religious LGBT groups. Because of the rather uninhibited behaviour of some LGBT people during such parades, this participation is viewed unfavourably by some religious people, but actually welcomed by some quite senior clerics on the grounds that it demonstrates to the ‘liberal elite’ that it is indeed possible to be gay and Catholic at the same time.

For Catholics at the present time, this theme is of particular interest because of the professed agenda of Pope Francis, not only in his present position but also in his previous incarnation as archbishop of Buenos Aires, to reach out to those on what he calls the peripheries of society, not just the obvious peripheries of poverty and social deprivation, but what he calls the ‘existential peripheries,’ which include remarried divorcees and LGBT people. Quite how this

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\(^1\) LGBT: initialism for Lesbian/Gay/Bisexual/Transgender
A laudable agenda is to be squared with traditional Catholic teaching is currently the subject of feverish debate among many Catholics.

In order to explore this theme, and how the stigma of being gay and Catholic can be dealt with, it seems necessary to do two things: firstly to explore the possible religious origins of the stigma LGBT people suffer; and secondly to examine which pastoral approaches have been found helpful for them in overcoming this.

**Religion and homosexuality**

It would be difficult to find a major religion that is entirely positive about homosexuality. Buddhism has been proposed as being at least neutral on this score, but, while Buddhists do not use Judeo-Christian categories such as sin to describe homosexual orientation and behaviour, at least some Buddhists seem to regard homosexuality as a misfortune, the result of bad karma from a previous life.

As regards Islam, scholars have pointed out that among the common misperceptions of ‘exotic’ Middle Eastern societies among Westerners has been its supposed tolerance of homosexuality among men, while in fact the authoritative Moslem texts are explicit in forbidding such behaviour. The only somewhat positive reference is a text in which Mohammed appears to show understanding of the attraction ‘beardless youths’ can hold for an older man, but warning against it.

Jewish and Christian texts contain explicit condemnations of homosexual behaviour, balanced only by references which some have interpreted as erotic to the intense friendship between Jonathan and the future king David, and the particular love of Jesus for one of his disciples, traditionally identified with St. John.

The main point of issue, of course, at least in Judeo-Christian circles, is how far traditional condemnations of homosexual behaviour can be applied to what many see as a completely new situation not envisaged by Biblical authors or traditional theologians, in which certain people do not just engage in homosexual behaviour, but experience their entire orientation as towards those of the same sex, either predominantly or wholly. Catholic theologian James Alison claims that this new situation requires a complete revision of Catholic attitudes to homosexuality, arguing that if Grace builds on Nature, as Catholics assert, the discovery of homosexual orientation is a simple fact of Nature, not a deviation from God’s design or from Natural Law, which moral theology must therefore take into account on its own terms.

It should be noted, however, that until recently, official Vatican documents on homosexuality have carefully eschewed references to it as a permanent orientation, no doubt for fear of opening the Church to precisely the kind of interpretation Alison gives. Instead, such documents distinguish carefully between homosexuality as a condition, which is described as objectively disordered but not sinful in itself, and homosexual behaviour, which is described as always gravely sinful.
Before going further, it may legitimately be asked, if this is the Church’s official position, how can an LGBT person not suffer from a sense of being stigmatised by the Catholic Church? Nevertheless, in one of the groups where I minister (see below for details) members quite happily accept this description of their state, and devote themselves to avoiding what they genuinely believe to be harmful behaviour by applying twelve-step processes to themselves, in a way analogous to alcoholism.

I would like to argue, however, that it is not Christianity per se that is responsible for homophobia and allied phenomena which still persist in our society. After all, alongside condemnation of homosexual behaviour, the Church offers pastoral care, spiritual direction and recourse to the sacrament of confession, all of which are intended to enable an LGBT Catholic to align themselves gradually with the Church’s teaching if they wish to do so. It also offers - not always intentionally! - many examples of leading figures within the Church, clerical and lay, who clearly were or are mainly homosexual by orientation, and who to some extent can serve as role models.

Instead, I would argue that it is something else which emerged in Western society in the Middle Ages, admittedly under Christian influence but not solely attributable to it, which is responsible for the stigma attached to LGBT people, namely the ideal of courtly love between a knight and his lady, what we usually refer to as the tradition of chivalry. This ideal, immortalised in such works as the tales of King Arthur and Dante’s Divine Comedy, transformed itself over time into the modern romantic notions of being in love, and the ideal of the nuclear family in which a man and a woman find contentment and fulfilment with each other and their children.

Of course, it was not the Western Middle Ages which invented the idea of men and women being in love. But the centrality of the ideal of chivalry and its modern equivalents may go some way to explaining a curious fact, which those who maintain Christianity as the culprit for homophobia will find hard to explain, a phenomenon noted by Gilles Herrada in his searching study of the modern homosexual soul, ‘The Missing Myth’.²

Herrada points out that when Christianity began to lose its dominant position in the West during the late eighteenth century, three of the major forces which succeeded it, adopting a position of general hostility to its tenets, were all implacably hostile to homosexuality, a fact hardly consistent with blaming Christianity for homophobia. These were the philosophy of the Enlightenment, the Communist party, and the profession of psychiatry. Indeed until not so long ago homosexuality was still viewed by the psychiatric profession as a mental illness.

If this hypothesis is correct, we may have to face the uncomfortable conclusion that acceptance of LGBT people by the modern liberal establishment is only skin deep, and that it is unrealistic to expect any heterosexual person to be free of homophobia in the deepest recesses of their mind. If this is the case, the stigma attached to LGBT people can only be removed by themselves, and this can only be done by finding what Herrada calls the missing myth to shore up the identity of the modern LGBT person. The challenge for religion is whether it can help in this process out of its own treasure house of stories, rather than deepen

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the identity crisis of LGBT people, and whether it can do that while remaining true to its own founding principles.

**Pastoral approaches to LGBT Catholics**

If one of the significant effects of stigma is to undermine a person’s sense of identity, it follows that pastoral care of LGBT Catholics must aim to build it up. The two main ways of doing this are through establishing support groups and through one-to-one spiritual direction or equivalents.

Support groups fall into two main categories: those set up by LGBT people themselves or their family members, and those set up by Church leaders. Not long ago I met an American man whose gay son lived near my parish and who described to me how in two separate locations where he lived in the United States he had taken the initiative in setting up local support groups for LGBT people and their family members, as a direct result of his son coming out as a gay man. In both groups, he reported, participants found great comfort in simply sharing experiences of what it was like to be gay and Catholic, or to have a close family member or friend who had come out as gay. He claimed that neither group had any agenda beyond mutual support: they did not take up any ‘political’ position, either in defence of the Church’s current teaching or attempting to change it. In both cases, he reported that the local priest and bishop – in one case even a Cardinal – had been extremely supportive.

Setting up such a group should usually be a relatively simple matter and can be of great help in overcoming the problem of stigma. Everyone knows they are welcome in such a group, whatever their situation, and whatever issues they are facing can be openly discussed. But in some cases matters are a little more complicated. In London, the bombing of a pub frequented by LGBT people, the Admiral Duncan, led to the formation of a Catholic LGBT support group which quickly began looking for priests to celebrate Mass for the group. While this may have been understandable, it soon aroused controversy, as some Catholics perceived the group to be a growing focus for open dissent from Church teaching, and queried the whole idea of a ‘gay Mass.’ The location of the group in Soho, and the dramatic circumstances of its birth, can only have strengthened this perception.

As a result the group itself became stigmatised and a very public polarisation emerged between supporters and opponents, which soon came to the attention of the Vatican itself and led to pressure on the local bishop to regularise the situation. Clearly such polarisation was not helpful in resolving the problem of stigma: in fact in one way it only increased it. After considerable discussion, a solution was found in relocating the group to the Jesuit parish in Farm Street, Mayfair, discontinuing the ‘gay Masses,’ and instead making the group publicly welcome at one of the regular Masses of the parish, where they hold a social event afterwards and continue with their other activities, including participation in London’s Pride March (see above.) The bishop is supportive of the group and appointed me as his liaison and chaplain to them over two years ago.

An example of the second type of group, those set up by bishops or priests themselves, is Courage, set up by Fr. John Harvey in the USA with the support of bishops there, and now
present in several countries including England. The Vatican has made it clear that bishops and priests can only set up such groups themselves if the groups are explicit in their adherence to Church teaching about the objective disorder of homosexuality and the sinfulness of homosexual acts.

Members of Courage and similar groups describe themselves not as gay but as ‘experiencing same-sex attraction,’ and aim at lifelong sexual abstinence - but not at changing their sexual orientation. A typical meeting has some similarities to a meeting of Alcoholics Anonymous, with members reminding each other of the goals of the group and sharing recent experiences in a non-judgmental atmosphere in which they explore the connection between their sexuality and other aspects of their lives, so as to find greater freedom from compulsive aspects of their behaviour.

The other main instrument of pastoral care is through one to one conversations between an LGBT person and a priest or other spiritual guide, involving perhaps ongoing spiritual direction or occasional meetings which may include the sacrament of confession. In such meetings, the minister will seek to communicate the unconditional love of Christ and his Church, and to accompany the person on his or her journey towards holiness. With LGBT people this ministry frequently encounters powerful feelings of pain and anger.

LGBT people often feel hurt by the Catholic Church, either because of the way its teaching comes across, or through concrete experiences of rejection, or both; those from non-Western cultures are sometimes even in danger of their lives; while some other Catholics seem threatened by the very existence of gay people, and react angrily towards attempts to accommodate them within the Church.

Anyone who ministers to LGBT Catholics soon realises that there is an extremely wide range of attitudes, experiences and behaviours among them. Some long for a permanent relationship, while others admit that relationships are not important for them, and they simply want sex. With the availability of gay websites and apps, and of well-known pick-up spots, most gay people in our society can easily have sex whenever they want.

We sometimes meet men who had a lot of casual sex but came to realise it did not make them happy. They may then seek help in leading a chaste life. Others are looking for a long-term relationship, but may go through several sexual partners in the search, sometimes remaining good friends with them after the sexual relationship has ended.

But one thing is common to virtually all LGBT Catholics today: they will not take the Church’s teaching on trust, but must learn from experience. Even those who hold a very traditional attitude have likely arrived at it through many experiences.

This being so, ministers to gay Catholics need two main resources: a moral theology that can face the critical scrutiny of life experience; and a well-grounded spirituality of discernment. These can help homosexual persons look honestly at their behaviour, see where it is leading them, and discover alternatives where indicated.
The moral theology I have found most helpful in this ministry is that of the Belgian Dominican, Servais Pinckaers,\(^3\) who shows that from Biblical times to St. Thomas Aquinas, Catholic moral theology was essentially based on the search for true happiness, on earth and in heaven, and on the cultivation of virtues leading to it; a happiness deeper than mere pleasure, and consisting above all in communion with God and his holy people.

A theology based on observing rules was a later distortion, and led by reaction in the 1960s to an equally unhelpful liberalism. In Pinckaers’ perspective, moral theology does not just define what one is allowed to do, or the minimum one must do, but joins hands with spirituality in promoting the search for holiness through loving God and neighbour to the uttermost.

The obvious spiritual partner for such a theology is the guidance given by St. Ignatius of Loyola on the discernment of spirits. As is well-known, these Rules for Discernment arose from Ignatius’ own experience, while recovering from a wound, of reading two types of literature: romantic tales which aroused him while he read them but left him dissatisfied when he put them down, and lives of the saints which he picked up with some reluctance but gave him an excitement which endured and led him to fantasise about imitating the saints concerned - which, of course, he eventually put into practice.

What is of interest to the practice of spiritually-informed psychiatry is that here we have a classic example of the intersection between the psychological - the awareness of feelings - and the spiritual - the discernment of their origin and meaning.

From a Catholic perspective, the most important gift the pastoral minister can offer LGBT people, after unconditional love and welcome, is encouragement to a deep spiritual life of friendship with Christ, based on the traditional practices of Mass, confession, Rosary, Scripture reading, etc. Without this, discernment loses itself in subjective states of mind whereas with it we begin to see which path leads to heaven and which to hell, and to marry personal experience with the age-old wisdom of the Church.

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The concept of ‘spiritual abuse’ is in the preliminary stages of being understood and recognised as a significant form of abuse that can cause lasting damage to victims, particularly in relation to their sense of identity, wellbeing and mental health. For many years, this has been regarded by the government as an ‘internal’ affair for religious organisations, who have been left to self-regulate their own practices. However, there is now growing concern that this is ineffective in ensuring that appropriate safeguarding measures are in place to protect vulnerable adults and children.

This issue is particularly pertinent to those who struggle – due to their religious beliefs - with questions of sexual or gender identity. Sadly, these individuals are subjected to the worst forms of spiritual abuse by groups of individuals at the time that they require unconditional support and affirmation. This has the added complication that their once safe place of ‘refuge’ (their church) becomes a place of turmoil and pain, where those they have trusted are the source of their abuse.

1. **Overview of Current Church Policy**

Most denominations have been slow to recognise the issue of spiritual abuse, with some still failing to do so. This has meant that little has been done to ensure any adequate safeguards or indeed training on how to recognise and address this issue.

a) **Church of England**

The concept of spiritual abuse was first officially recognised as a specific form of abuse in the 2006 Archbishops’ Council report ‘Promoting a Safe Church’.¹ This report, endorsed by the House of Bishops, had been prepared in response to the Department of Health’s ‘No Secrets’² (2000) and ‘Safeguarding Adults’³ (2005), which recognised the need for good safeguarding practices for all adults – not just children.

The section on ‘Spiritual Aspects of Abuse’ (Appendix 2.2) was vague, stating simply:

‘Churches need to be sensitive so that they do not, in their pastoral care, attempt to ‘force’ religious values or ideas onto people, particularly those who may be vulnerable to such practices. Within faith communities harm can be caused by the inappropriate use of religious belief or practice; this can include the misuse of the authority of leadership or penitential discipline, oppressive teaching, or intrusive healing and deliverance ministries, which may result in vulnerable people

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¹ Promoting a Safe Church Policy for Safeguarding Adults in the Church of England. *Church House Publishing*, 2006
² No Secrets – Guidance on Protecting Vulnerable Adults in Care, Department of Health, 20th March 2000
³ Safeguarding Adults – A National Framework of Standards for good practice and outcomes in adult protection work. The Association of Directors of Social Services, October 2005
experiencing physical, emotional or sexual harm. If such inappropriate behaviour becomes harmful it should be referred for investigation in the usual way. Careful supervision and mentoring of those entrusted with the pastoral care of adults should help to prevent harm occurring in this way. Other forms of spiritual abuse include the denial to vulnerable people of the right to faith or the opportunity to grow in the knowledge and love of God.’

The next safeguarding report to refer to spiritual abuse was the 2011 ‘Responding Well to Those Who Have Been Sexually Abused’. Importantly, this recognised the historic issue behind the problem that ‘spiritual abuse is not covered within the four-fold definition of abuse (as defined by the government as physical, sexual, emotional abuse and neglect) but is of concern both within and outside church communities.’

Whilst the document naturally focused on the issue of sexual abuse, the section on ‘Spiritual Abuse’ was clearer about some aspects of the damage suffered by victims:

‘Those people who are abused by clergy suffer profound spiritual abuse. The abuse shatters the victim’s relationship and trust in the Church, severely impacts on the ability to maintain any connection with the sacred, and creates profound confusion and doubt about God’s love for the victim. Kennedy identified a dual traumatization for these victims, namely the abuse itself and the response of the Church: ‘When women reported their experiences using official structures and avenues open to them, the response was at best mixed and at worst damaging.”

In 2014, the Church of England appointed a National Safeguarding Adviser, Graham Tilby, whose work has significantly aided the church in focusing on the need to address a range of abusive practices. Notably, in Appendix 1.1 of the March 2017 ‘Responding Well to Domestic Abuse’ report, the Church of England formally recognised additional categories of domestic abuse to those defined by the government, which included spiritual abuse:

**Definition of Domestic Abuse**

The cross-government definition of domestic abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse perpetrated by those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial, emotional.

The Church recognises additional categories of neglect, spiritual and digital abuse.

It then went on to describe spiritual abuse as follows:

‘For example, telling someone that God hates them; refusing to let them worship (e.g. not allowing a partner to go to church); using faith as a weapon to control and terrorize them for the perpetrator’s personal pleasure or gain; using religious teaching to justify abuse (e.g. ‘submit to your husband’), or to compel forgiveness.’

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4 Responding Well to Those Who Have Been Sexually Abused. Church House Publishing, July 2011
5 Responding Well to Domestic Abuse – Policy and Practice Guidance. Church House Publishing, March 2017
Of arguably greater significance, however, is the fact that this report was the first to recognise how religious texts can be used to justify abuse (see Appendix 3 of report).

b) Methodist Church
The signing of the Anglican-Methodist Covenant\(^6\) in 2003 has led both denominations to work together on areas of common policy, such as the 2010 Joint Statement on Safeguarding Principles\(^7\). In the policy booklet that accompanied this statement, the Methodist Church acknowledged the issue of ‘spiritual and ritual abuse’ but then – as with the Church of England’s statement - gave little advice on how to address it:

‘In the church context there has been developing realisation that spiritual abuse is another form of harm. The Church of England ‘Guidelines for the Professional Conduct of the Clergy’ cautions those who minister to beware of abusing their position. In ‘Domestic Violence and the Methodist Church – the Way Forward’, there is evidence of spiritual abuse issues.

Churches need to be sensitive so that they do not, in their pastoral care, attempt to ‘force’ religious values or ideas onto people, particularly those who may be vulnerable to such practices. Within faith communities harm can be caused by the inappropriate use of religious belief or practice: this can include the misuse of the authority of leadership or penitential discipline, oppressive teaching, or intrusive healing and deliverance ministries, which may result in vulnerable people experiencing physical, emotional or sexual harm. Other forms of spiritual abuse include the denial to vulnerable people of the right to faith or the opportunity to grow in the knowledge and love of God.

If such inappropriate behaviour becomes harmful it should be referred for investigation in the usual way. Careful supervision and mentoring of those entrusted with the pastoral care of adults should help to prevent harm occurring in this way.’

c) Catholic Church
To date it has not been possible to identify any publicly available report or document that recognises or addresses the issue of spiritual abuse within the Catholic Church.

d) Baptist Church
The Baptist Union Safeguarding Policy does recognise spiritual abuse as a form of abuse, even if it is ‘not one of the official definitions of abuse’. The following is available on the Baptist Union website, under the section ‘Understanding Abuse’\(^8\):

‘Spiritual abuse’ is increasingly being used to describe those situations where an abuse of power takes place in the context of a faith community. The following is a widely used definition of spiritual abuse:

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\(^6\) [http://www.anglican-methodist.org.uk/text.htm](http://www.anglican-methodist.org.uk/text.htm)

\(^7\) Safeguarding Children and Young People – Policy for the Methodist Church. *Methodist Publishing*, April 2010

\(^8\) [http://www.baptist.org.uk/Groups/220834/Understanding_Abuse.aspx](http://www.baptist.org.uk/Groups/220834/Understanding_Abuse.aspx)
‘Spiritual abuse occurs when someone uses their power within a framework of spiritual belief or practice to satisfy their own needs at the expense of others.’

The section continues by outlining the various forms spiritual abuse that can and have taken place with children, such as that which led to the death of Victoria Climbie. It then questions whether the specific belief in demon possession of children is spiritual abuse or in fact an excuse ‘to justify and condone the physical and emotional harming of children.’

Helpfully it lists examples of how this practice can lead to the abuse or neglect of children:

- a belief in demon possession resulting in the labelling and naming of a child as ‘evil’ or a ‘witch’
- placing pressure on children to make decisions that are not appropriate to their age or developmental stage
- creating an environment in which children are discouraged from asking questions or holding alternative views

2. Defining Spiritual Abuse

In 2013, Dr Lisa Oakely, Programme Leader of Abuse Studies at Manchester Metropolitan University, defined spiritual abuse in her book ‘Breaking the Silence on Spiritual Abuse’ as follows:

‘Spiritual abuse is coercion and control of one individual by another in a spiritual context. The target experiences spiritual abuse as a deeply emotional personal attack. This abuse may include: manipulation and exploitation, enforced accountability, censorship of decision making, requirements for secrecy and silence, pressure to conform, misuse of scripture or the pulpit to control behaviour, requirement of obedience to the abuser, the suggestion that the abuser has a ‘divine’ position, isolation from others, especially those external to the abusive context.’

This definition has since been adopted by the Churches’ Child Protection Advisory Service (CCPAS) and other church organisations. As such it focuses on the abuse perpetrated by an individual (normally someone ‘in power’) over another individual (normally a congregant).

The most typical incidents involve those in leadership who have frequently achieved a ‘cult-like’ or ‘guru’ status due to their charismatic personality and strong leadership style. This is most evident in large evangelical churches, particularly those with a Charismatic or Pentecostal background, where leaders exercise ‘gifts of the Holy Spirit’ and are therefore recognised by their congregations as being ‘chosen and anointed by God’. As a result, their word can become infallible and their authority unquestioned. For the purposes of this document this type of abuse will be called the ‘Individual Leader Model of Spiritual Abuse’.

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However, the question then arises as to whether the abuse can also be perpetrated by a group of individuals. This could be a whole church, or a group of individuals within a church (e.g. home group) or that of a whole network of churches. Turning once again to the Oakley definition of spiritual abuse it is possible to apply many of her characteristics to such groups:

- pressure to conform
- misuse of scripture or the pulpit to control behaviour
- requirement of obedience to the abuser
- the suggestion that the abuser has a ‘divine’ position
- isolation from others, especially those external to the abusive context.

For the purposes of this document, this type of group abuse will be called the ‘Group Model of Spiritual Abuse’, where it is a form of church community – rather than an individual – that perpetrates the abuse, and so causes significant long-term harm to their victims.

3. The Group Model of Spiritual Abuse

This is a far subtler - albeit unconscious - form of control compared to the ‘Individual Leader Model’, and is mostly due to the formation of a group dynamic that is unique to certain types of churches and network groups.

Much of this is driven by the ‘spiritual atmosphere’ that is created during the teaching and worship times, and especially the prayer ministry sessions. An emotionally safe and open ‘spiritual space’ is established by a mix of factors, which include the choice of worship songs, a modern open-plan worship space and a laidback approach to dress codes. Surrounded by a large number of like-minded people (often in their thousands), worshippers are frequently encouraged to overcome their inhibitions and raise their hands and/or dance. The impact of this is that a group norm is created, where people are led to feel that whatever happens during prayer ministry must be both normal and spiritual. Such sessions are overseen by leaders who have a powerful air of authority. This makes it very difficult for people to question or show concern about what is happening, and can feel akin to ‘pressure selling’ where individuals feel obliged to comply. Dissenters who do not conform to the group norm (such as LGBTI Christians, divorcees and single parents) are frequently viewed as lacking in faith or spiritual maturity, and are often subsequently viewed with caution and scepticism.

A key common group dynamic is the church’s attitude to the Holy Spirit, particularly the belief in the importance of being baptised in the Holy Spirit. This forms the core part of the now global Alpha Course, where in Week 9 of the 10-week programme people are invited to attend a Holy Spirit weekend in order to be ‘baptised in the Spirit’. Many other evangelical ministries and networks also offer similar opportunities to be baptised in the Holy Spirit, such as:

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10 Initialism for Lesbian, Gay, Bisexual, Transgender, and/or Intersex
Indeed, the Evangelical Alliance website lists nearly 50 prayer ministry organisations, most of whom will exercise “gifts of the Spirit”, such as speaking in tongues, words of knowledge or discernment of spirits.

4. Common Spiritually Abusive Practices
To be clear, the vast majority of these ‘group models’ do not set out to be abusive. However, the combination of their unquestioned teaching on the Holy Spirit coupled with their common worship dynamic can lead to a variety of abusive practices such as:
- Taking a leader’s word as read on key issues, given he/she is God’s ‘anointed’ leader
- Believing that failure to be baptised in the spirit is due to some undisclosed sin/curse
- Believing that failure to be healed after prayer is due to some undisclosed sin/curse
- Misusing ‘words of knowledge’ and/or ‘prophecy’ to control and subjugate people
- Putting pressure on people to give financially in order to ‘release’ God’s blessing

The most damaging practice is often the misuse of scripture during times of prayer ministry, where passages are quoted (such as those below from the NIV) that can make the individual receiving prayer feel that their failure to be healed is due to their sin:
- ‘When you ask, you do not receive, because you ask with wrong motives’ (James 4:3)
- ‘But when you ask, you must believe and not doubt, because the one who doubts… should not expect to receive anything … Such a person is doubleminded and unstable in all they do’ (James 1:6-8)
- ‘For I, the Lord your God, am a jealous God, punishing the children for the sin of the parents to the third and fourth generation of those who hate me.’ (Deuteronomy 5:9)

5. The Spiritual Abuse of LGBTI Christians
A large proportion of these types of churches and network groups believe that ‘the Bible is clear that homosexuality is a sin’. As such they will teach, despite significant evidence to the contrary, that they are the only ones who take scripture seriously and that:
- Engaging in acts of same-sex love is an abomination (Leviticus 20:13)
- Practising homosexuals will go to hell (Romans 1:26-32)
- God made us only ‘male and female’ (Genesis 1:27)
- ‘Sex is only for marriage’, which can only ever be between a man and a woman

LGBTI Christians in these churches are therefore taught that they must live abstinent lives if they want to be ‘proper Christians’. They are told that ‘this is the cross that they are called to bear’, but are then reassured that ‘this is the only for this life’. The other option often taught is to trust God for healing and get married to someone of the opposite sex.

This abusive teaching leads LGBTI Christians to go through three common phases:
i) The Silent Confusion Phase
This is normally suffered alone as the victim knows that sharing their struggle will place them on the church’s ‘unsound naughty step’. Typical internal dilemmas are:

- If God loves me, how can He create me with a desire that is ‘abominable’?
- Will acting on this desire truly bring me happiness, or is it just temptation?
- How do I satisfy my desire for love and intimacy if I can never be in a committed long-term relationship?

ii) The Church Healing Phase
Many will experience breakdown during Phase One, after which they will often seek help from mostly untrained prayer ministry personal, who will pray through:

- Their life history to identify areas of emotional healing that might be needed
- All their past sins, meaning they are asked to divulge their most intimate secrets
- Any “generational curses” that may come from parents and/or grandparents

iii) Conversion Therapy/Deliverance Phase
Normally, when their local prayer ministry does not work, the individual is then recommended to attend a specialist ministry that can help deliver them from their ‘unnatural desires’. They are urged by their peers to submit to the healing process, which often involves periods of fasting, and can cost quite a lot of money.

6. The Consequences of Coming Out for LGBTI Christians in these ‘Groups’
The Evangelical Alliance (EA) has provided a resource document for church leaders as to how they might best respond to the issue of homosexuality. Entitled ‘Affirmations’11, it summarises in ten points the EA position about how to deal with the LGBTI Christians in EA member churches. This has recently been adopted by various organisations, including members from the Church of England’s Evangelical Group on General Synod.

Of greatest concern and a significant cause of spiritual abuse are the final two points:

9. We believe both habitual homoerotic sexual activity without repentance and public promotion of such activity are inconsistent with faithful church membership. While processes of membership and discipline differ from one church context to another, we believe that either of these behaviours warrants consideration for church discipline (author’s emphasis).

10. We encourage evangelical congregations to welcome and accept sexually active lesbians and gay men. However, they should do so in the expectation that they, like all of us who are living outside God’s purposes, will come in due course to see the need to be transformed and live in accordance with biblical revelation and Orthodox Church teaching (author’s emphasis). We urge gentleness,

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11 http://www.eauk.org/church/resources/theological-articles/resources-for-church-leaders-biblical-and-pastoral-responses-to-homosexuality.cfm
patience and ongoing pastoral care during this process and after a person renounces same-sex sexual relations.

As a result, LGBTI Christians who decide to ‘come out’ and enter same-sex relationships face ‘church discipline’. Recent testimonials from LGBTI Christians show this includes:

- Being removed from any form of lay leadership (such as being in the worship group, serving communion, doing the prayers or readings, helping with children’s church)
- Having letters sent to neighbouring church leaders warning them about an individual
- Being asked to leave a church if no repentance or change in behaviour is forthcoming

Even if they are not formally asked to leave, many choose to do so as they find the pain of rejection and humiliation hard to deal with, especially at such a vulnerable time. They are therefore left without any form of supportive community, and frequently find they are deserted by church friends who up till then have been their main source of support.

7. Impact of Spiritual Abuse on LGBTI Christians

The significant long-term harm that these church practices cause cannot be underestimated. Whilst an in-depth academic study is required, a top line summary shows victims experience:

- Intense sense of guilt and shame for having ‘unnatural desires’, frequently exacerbated by the continual failure of prayer ministry to deliver any form of long term ‘healing’
- Self-hatred for being LGBTI, which frequently becomes deeply internalised homophobia
- Repression of all forms of feelings and desires, which can lead to emotional breakdown and other mental health issues
- Significant levels of internalised anger, leading to high levels of depression
- Significant levels of fear, both at being ‘found out’ or of being labelled ‘unsound’
- A striving to ‘be good and do good’ in order to try to bring about their healing
- A belief that one must ultimately choose between following God and being loved/happy

Sadly, this often proves too much for many LGBTI Christians, some of whom have tragically chosen to take their lives as a result. Others can turn to self-harm. Indeed research conducted by has shown that a large proportion will suffer from long term mental health issues.

8. Conclusion

In 2017, the Oasis Foundation published a report ‘In the Name of Love – the Church, Exclusion and LGB Mental Health Issues’\(^\text{12}\) that highlighted what a wide range of health care professionals and academics now agree:

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\(^{12}\) In the Name of Love – the Church, Exclusion and LGB Mental Health Issues, Oasis Foundation, February 2017
'LGB problems with mental health are as a result of discrimination and a sense of societal inferiority...arising from explicit statements or implicit assumptions that heterosexuality is superior to homosexuality or bisexuality.'

In particular, it sought to lay a large part of the blame at the door of the Church:

‘The Church and local churches are one of the biggest sources of direct discrimination against LGB people and the biggest contributor of negative views to debates about same-sex relationships in society and the media.’

Until the specific issue of Spiritual Abuse against LGBTI Christians is recognised and addressed, particularly the ‘Group Model’ outlined above, then the high rate of suicide, self-harm and depression amongst LGBTI Christians will continue to go unabated.

It is imperative that professional organisations external to the religious institutions call for better safeguarding measures against spiritual abuse. Indeed, they should look to recognise it as a key form of abuse at a national level so as to ensure that some of the most vulnerable in our society are afforded the same protection as those facing other forms of abuse.

Jayne Ozanne is a prominent gay evangelical who works to ensure full inclusion of all LGBTI Christians at every level of the Church. Having been a founding member of the Archbishops’ Council for the Church of England (1999 – 2004) she is now once again a member of General Synod where she is involved in campaigning for a range of issues. She is actively engaged through her writings and broadcasts in helping the Church develop and promote a positive Christian ethic towards lesbian, gay, bisexual, transgender and intersex people.

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A case for informing patients of the mental health benefits of religion

Dr Calum Miller

Introduction

In the United Kingdom, the received wisdom on the doctor-patient relationship with regard to religion is that it is fundamentally a microcosm of the mostly secular wider public sphere: religion is allowed, but the relevant authorities are reticent to bring it up, and there is a certain anxiety that the potential career cost associated with the subject – regardless of who instigated the discussion – is too great to be worth it. Thus, Alastair Campbell’s famous, ‘We don’t do God’, when Tony Blair was asked about Christianity. And, correspondingly, the concerns among Christians in the NHS (Bowcott, 2009) following the temporary suspension of community nurse Caroline Petrie for offering to pray for a patient in 2008 (Savill, 2009).

Recent political and legal events have yielded mixed signals for Christians. The ascension of a new Conservative government has been met with ambivalence from traditional Christians, who may welcome their contributions to the ‘new visibility of religion’ but who harbour reservations about other parts of their platform. The recent assurance from Theresa May that ‘we would all want to ensure that people at work do feel able to speak about their faith’ (Swinford, 2016) sets some political precedent for an expanded role for Christianity in the public sphere, but as of yet has not been paralleled by any significant legislative or judicial reform. Indeed, it came just days before the deposition of staff nurse Sarah Kuteh on the grounds of various complaints related to her ostensible religious harassment of patients (Finnigan, 2016).

The full details of the latter case are yet to emerge, and indeed it may well transpire that her actions constituted such a breach of professionalism as even most evangelism-minded Christians would disavow. But it nevertheless forms part of the current narrative contributing to the unease of Christians discussing religion in healthcare settings. Even if we suppose that the guidelines in this respect are unambiguous, and that the anxieties are misconceived, the apprehension of Christian clinicians about crossing the boundary may have undesirable consequences. On the one hand, it could push some Christians so far to the opposite extreme that Christian healthcare workers lose out unnecessarily on integrating their spiritual and professional vocations,¹ and on the other hand, it could multiply² and gratuitously deprive patients of a valuable spiritual and mental health resource.³

¹ I take this to be a genuinely important interest, since as a society we want people to flourish, and just as this flourishing involves encouraging and facilitating people to pursue their interests and values and to feel satisfied with their work and life more generally, so the same principle should be extended to those who hold religion to be interesting and valuable. That is not to say that this interest is indefeasible.
² ‘Multiply’, since many patients simply appreciate having a sympathetic clinician who shares the same values, beliefs and rituals, and also since – as I argue shortly – religious engagement is positively correlated with improved mental health, the mechanism of which correlation is controversial but probably manifold.
³ There is at the very least robust anecdotal evidence for this, though the quantification of this problem remains an open question: I anticipate that some of the evidence presented herewith goes some way towards answering
My aims in this essay are exploratory and argumentative: I will outline current professional guidance for doctors discussing their personal (including religious) beliefs with patients, before briefly summarising the evidence most relevant to my case. Building on this, I will argue that professional guidance – currently ambiguous – should clarify (in the affirmative) the permissibility of a certain kind of religious discussion: viz., doctors informing patients that religion is associated with improved mental health, regardless of whether the patient has indicated an interest in religion or not. My essay will use a standard academic philosophical and ethical framework: I will lay out the relevant empirical evidence, then offer a pro tanto reason in favour of my thesis, and finally argue that there are no counter-considerations overriding this initial reason.

**Current guidance**

Contra those who think that virtually any substantive discussion of religion between doctor and patient is suspect in the eyes of the General Medical Council, there is some surprisingly liberal counsel offered by the GMC: disclosing personal beliefs is explicitly permitted, and the importance of noting the influence of patients’ religious views is noted, but there are clear regulations on such discussions:

‘You may talk about your own personal beliefs only if a patient asks you directly about them, or indicates they would welcome such a discussion.’ (GMC, 2013a, para. 31)

‘You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.’ (GMC, 2013a, para. 54)

There is already some ambiguity introduced here: ‘indicates they would welcome such a discussion’ clearly has a fairly substantial subjective element. Even more unclear, however, is the advice regarding professionalism:

‘If you disclose any personal information to a patient, including talking to a patient about personal beliefs, you must be very careful not to breach the professional boundary that exists between you.’ (GMC, 2013a, para. 30)

The Royal College of Psychiatrists’ guidance is more elaborate regarding the propriety of religious discussion in clinical contexts:

‘A tactful and sensitive exploration of patients’ religious beliefs and spirituality should routinely be considered and will sometimes be an essential component of clinical assessment.’ (RCPsych, 2013, p. 10)

It goes on to reiterate GMC guidance on professionalism:

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It. There is also considerable survey evidence suggesting that patients want their religious needs to be addressed (Nicholls, 2002).
‘Psychiatrists should not use their professional position for proselytising or undermining faith and should maintain appropriate professional boundaries in relation to self-disclosure of their own spirituality/religion.’ (2013, p. 10).

These latter guidelines, similarly, are not as determinative as we might like. In particular, this paper examines one grey area which, it seems, has no clear judgment afforded to it by any current guidelines. This is as follows: is it permissible for doctors to inform patients of the potential mental health benefits of religion, regardless of whether a patient has indicated that they would welcome a discussion of this sort? And is it permissible for doctors to recommend religion as part of a treatment plan for certain mental health disorders? And, derivatively, supposing the answer is yes, in what form should this take? I shall primarily be answering the former question, but the reasons I offer in favour of this are at least suggestive of answers we might give to the latter two.

As I explained earlier, even if current guidelines actually permit this, it is far from clear that they do so. But the fact that many doctors do not feel comfortable doing so — and the consequent deprivation of flourishing to doctors and patients to which I pointed — are reasons for correcting this formally by codifying its permissibility and its limits.

It is worth identifying more clearly some of the sources of the ambiguity. There are at least two sources identifiable in the guidance cited. The first is what constitutes a ‘personal belief’. It cannot simply be any belief about which there is widespread disagreement among the general public, since then even descriptive facts like ‘the MMR vaccine does not cause autism’ would escape the doctor’s inventory. Nor can it be any belief about which there is widespread disagreement between doctors, for many treatments for which there is a controversial evidence base ought still to be permitted by the relevant experts so long as they can cite substantial evidence for their case. These definitions are too sensitive in their inclusion of reasonable descriptive counsel from doctors. But other definitions seem too insensitive — failing to exclude some beliefs many would want to count as ‘personal’ and therefore out of bounds. So, for example, defining personal beliefs as normative/prescriptive beliefs, while perhaps capturing a wide range of what we want to exclude — many religious, political and ethical views — will not suffice to rule out descriptive religious beliefs — doctrines about God or beliefs about the historical Jesus, for example. In any case, as I will argue later, it is hardly the case that medicine is already value-neutral: though there is significant scope for individual value systems, doctors and health economists are still required to make some judgments about what constitutes healthy cognition and healthy beliefs about oneself — for example, judging anorexic cognitions to be unhealthy and as warranting discouragement.

In any case, it does not seem as though the fact of the empirical correlation between religious engagement and improved mental health is something that can be excluded from clinical practice on the grounds of it being a ‘personal belief’. It is a fact that can easily be recognised by people of any religious inclination and that has no strict prescriptive entailments. So it is far from clear that the counsel on personal beliefs is the most salient guidance for this case.

What constitutes a professional boundary may be even more opaque. Unfortunately, the explanatory guidance on professional boundaries (GMC, 2013b) pertains primarily to sexual relationships and secondarily to ‘improper emotional relationships’, but it is difficult to see...
how the case suggested here amounts to forming an improper emotional relationship. So it is difficult to understand what is meant by professionalism and where the professional boundaries lie. One possibility is that the entirety of the GMC’s ‘Good Medical Practice’ is supposed to constitute professionalism. But this is still not quite adequate, since it makes commands to be professional within the document (including the guidance on the case in question) entirely redundant – they amount just to telling doctors to follow the rest of the rules in the guidance. And it is unlikely that the GMC want to claim that ‘Good Medical Practice’ is comprehensive – that they could not take disciplinary action for lack of professionalism over anything not clearly covered therein. So it seems that ‘professionalism’ is lacking clear delineation and explication.

The relevant evidence

The literature on religion and mental health is now so extensive that it is difficult to provide a neat summary of it. Major turning-points in assimilating and presenting the overwhelming body of evidence were the publication of Harold G. Koenig’s *Handbook of Religion and Mental Health* in 2001, and its follow-up 2nd edition in 2012. The content of the literature is broad: the varied range of psychiatric conditions and the varied aspects of each condition are paralleled by the varied range of religions and aspects of each religion. This leads to an enormous number of permutations of variables, thereby generating a much more complex relationship that does not permit a simple positive or negative evaluation. Beyond this, there are the issues of the mechanisms by which religion is correlated with mental health, the extent to which religion should be involved in healthcare, the direction of the relationship, how mental health is treated within religious communities, and so on. The relevant empirical facts for the present argument, however, are those showing that some reasonably well delineated kinds of religious engagement are associated with improved mental health, and that there is some evidence that there is a causal relationship – though this latter clause is not strictly necessary for the argument.

This main premise is well established and accepted, though there is considerable disparity between the various mental disorders in this respect. In this essay I do not seek to defend this premise, so I take here Simon Dein’s summary of the state of the evidence:

On balance those who are more religious have better indices of mental health ... On balance being religious results in more hope and optimism and life satisfaction ... less depression and faster remission of depression ... lower rates of suicide ... reduced prevalence of drug and alcohol abuse ... and reduced delinquency ... Findings in relation to anxiety are mixed ... Work on schizophrenia is still embryonic; recent studies however in Switzerland suggest that religious individuals with psychotic illnesses frequently deploy prayer and Bible reading to help them cope with their voices, and higher levels of religiosity may increase medication compliance. (Dein, 2013)
This does not cover the wide range of psychiatric illness, but the disorders noted here represent the large majority of mental illness in the UK (McManus et al., 2016). That said, there is a plausible case to be made that mental health is not simply the absence of any disorder characterised in the DSM-V or ICD-10. For one thing, mental health may involve flourishing (the reader may decide whether this may comprise happiness, holiness, or something else) rather than just absence of infirmity. There is not as much evidence pertaining to mental flourishing and religion – perhaps partly on account of its subjectivity – but there are some cross-sectional studies showing improved indices of subjective wellbeing among religious populations in the UK, and particularly among Christians (ONS, 2015; Spencer et al., 2016). Interestingly, in the Office of National Statistics’ Survey, those belonging to religions other than the major religious traditions uniformly had poorer measures of wellbeing (given here as life satisfaction, feelings that life is worthwhile, happiness and lack of anxiety). This may correspond to the fact that ‘People who have a spiritual understanding of life in the absence of a religious framework are vulnerable to mental disorder’, as a recent study concluded (King et al., 2013). This may, in fact, help generate the constraints on my proposal which some critics allege would be too difficult to generate. But the evidence and its interpretation is more rudimentary when it comes to mental flourishing as opposed to mental disorder.

A second similar complication is that, for example, depression is a far more specific diagnosis than low mood. So many people with low mood will not fit the diagnostic criteria for depression, and so may be missed when measuring incidence of depression on a population basis. Depression is characterised not only by low mood but by, for example, self-critical cognition, poor sleep, and poor appetite (or overeating), among other things. It may well be that low mood has a different relationship with religious engagement when compared with the other symptoms of depression. And it may be that low mood falling short of any diagnosis is not represented in many studies, even though it is patently of interest to mental health professionals.

For the purposes of this paper, I cannot explicate the detailed relationship between religion and mental health. I am committed only to the theoretical result that, given that some kinds of religious engagement are positively associated with some kinds of improved mental health, doctors should be able to inform those with the relevant mental health needs of the benefits of the relevant kinds of religious engagement. I am here only marking the fact that this principle may be extended to a wider conception of mental health if and when the evidence permits it.

A policy proposal

Having briefly described the relevant socio-political, regulatory and scientific contexts, I am now in a position to set forth my proposal:

[Thesis] It should be clearly and formally permissible for clinicians to objectively and dispassionately inform patients suffering from certain mental health problems

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4 I take it that the distribution of psychiatric illness in the rest of the UK is roughly similar to warrant the generalised claim.
that the relevant kinds of religious engagement are positively associated with improved mental health, even without explicit solicitation from the patient.

There is a *pro tanto* reason\(^5\) in favour of my thesis as follows: physicians should recommend intrinsically benign\(^6\) things for which there is good reason to think that they improve health. *A fortiori* (since it is a weaker proposition\(^7\)), they should at least *inform* patients that certain intrinsically benign things probably or plausibly improve health. *A fortiori* still, it should be *permissible* for clinicians to do so, even if not obligatory. That is, something’s being conducive to mental health is a *pro tanto* reason to permit clinicians to inform patients about it – at the very least. This much seems uncontroversial. The question is whether there are such countervailing considerations in this case – are there reasons to forbid clinicians from doing so despite the *pro tanto* reason in favour of it? I will argue that there are not.

There is a relative paucity of literature answering the question I have posed in this paper, so the objections given here are generated tangentially: some occur in literature on whether, for example, psychiatrists ought to pray with patients (e.g. Poole & Cook, 2011). I do not have space to discuss all possible objections, so I will identify and briefly rebut the most salient, as they appear to me.

1. Prevention of abuse

At the heart of much objection to the integration of religion and psychiatric practice is that laxity of the professional boundaries which currently resist significant religious integration could invite abuses of the shifted boundaries. Thus, Poole et al. argue, ‘The problem with blurring the boundaries by inviting an apparently benign spirituality into the consulting room is that it makes it more difficult to prevent these abuses. Having moved the old boundary it is then very difficult to set a new one’ (Poole, 2008, p. 356; see similarly, Carter, 2008). A related objection is that religion can sometimes be harmful to mental health.

In response, I note that vulnerability to abuse is a feature of virtually anything in medicine, and particularly within psychiatric practice. While it may be that drug prescription has tighter regulations and so is less vulnerable to abuse, there are still areas where we permit doctors significant latitude where abuse is possible, because ordinary human interaction would be stifled without it. Thus, expression of sympathy – including tactile – is often appropriate in clinical settings even though it is open to abuse. We already give doctors huge responsibilities and significant laxity such as might admit of abuse. The possibility of abuse is not ordinarily enough to radically restrict doctors’ practice: rather, clear guidance regarding what would constitute abuse is ordinarily more appropriate and respectful of religious needs than creating gratuitous and harmful restrictions. The ‘harmful’ clause applies in this case, since the relevant ban would deprive patients of a potentially helpful element of their treatment.

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\(^5\) A *pro tanto* reason is one which, in the absence of countervailing moral reasons, gives one (overridable) reason to perform an action.

\(^6\) By which I mean something which is not intrinsically bad.

\(^7\) A proposition X is weaker than Y if Y entails X but X does not entail Y. It can be formally proved that in such cases, the probability of X is greater than that of Y. Even though the latter claims here are not strictly entailed by the former, it seems clear that they are more plausible than the former.
I briefly alluded to one way in which the relevant regulations might be generated above, when noting that the mental health benefits seem to apply primarily to those within mainstream religions, while the opposite trend is noted in idiosyncratic spirituality. There are other ways in which extensions of my proposal might be regulated, which I do not have time to discuss in detail here. But most relevantly, my proposal here is implicitly regulated, so does not require any radical revision or vagueness of boundaries. It is simply that where there exists evidence that a certain kind of religious engagement is conducive to mental health, clinicians should be permitted to relay that information to patients. This would set little to no precedent in favour of abuse in more ambiguous situations.

Finally, my proposal is manifestly consonant with existing practice in this area. For the NHS already provides chaplaincy services which might be equally prone to abuse. And GMC guidelines already permit discussion of personal beliefs with patients, subject to various constraints. So there would be no real boundary shift, and nor does it seem as though the mere possibility of abuse is considered sufficient to preclude religious involvement in healthcare. The same is true in this case.

2. Causation and correlation

One objection is that there is no clear causal link suggested, so implying that religious engagement may help the patient may be premature. In response, I note that the premise of the objection is exaggerated. There is some interventional research of relevance (Worthington, 2011), but in any case the implication that randomised controlled trials are the only possible source of causal information is untrue. Observational studies may have considerable evidential force regarding causation when adjustments are made for plausible confounding factors. We did not need a randomised controlled trial to know that smoking is bad for one’s lungs.9

Further, there is no reason why this cannot be conveyed to the patient. It may be explained to the patient that the evidence is more equivocal than with other interventions, though at least as good as the evidence for many other interventions in medicine. It may be explained that the causal links are unclear but that the association is nevertheless present and may justify religious engagement in the service of mental health. Patients ought not to be condescended to by being kept ignorant about potentially helpful information on the assumption that they could not possibly tell the difference between correlation and causation.

Objections in this vicinity may offer plausible confounding factors rendering the religious element redundant. For example, it may be that being part of a community explains why religious people tend to have better mental health. Then we might simply recommend being part of a community generically rather than mentioning religious communities in particular.

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8 For example, I also think that prayer should be permitted in clinical practice: one way to protect this from abuse would be to develop set prayers for use in clinical contexts which are ecumenically robust and pertain to less controversial themes within a given tradition: that God heals and comforts within Christianity, for example.
9 Thus, the NHS website misleads when it says that ‘As a cohort study, this research cannot tell us about any potential causal link between belief and treatment.’ (NHS, 2013)
It is probably true that much of the mental health benefit of religion is related to the religious community. That said, it is equally likely that other aspects of religious engagement make their own contributions, so recommending communities generically will not optimise the mental health benefits. Moreover, this is hardly a reason not to mention religion in this context: if religious communities are paradigmatic examples of health-conducive communities, it seems eminently reasonable to note to patients that these are good examples of communities which the patient may consider joining in an effort to advance their own mental health. Finally, even in the unlikely case that the religious element were redundant, this is hardly a reason for banning the mention of religion in this context. At the very most, it might suggest that my argument only supports permission, rather than an obligation, for clinicians to give the information in question.

3. Expertise and solicitation

Poole (2011) notes that prayer lies outside doctors’ expertise as part of his argument against praying with patients. It may be felt similarly here that religion in general is outside the expertise of doctors. A similar objection might be raised to the ‘explicit solicitation’ clause in my thesis: patients, especially irreligious ones, visit doctors to improve their health, not to learn about religion. My proposal may be akin to doctors informing patients that the manuscript attestation for the New Testament far exceeds any other text from antiquity. This would be an empirical fact, but would hardly be appropriate (without solicitation, at least) in a psychiatric consultation.

One response here is to note that much of what doctors do is not strictly part of their expertise, and may not be solicited. For example, apart from some interpersonal skills selection before and an occasional communication skills aspect of an examination during medical school, there is precious little substance to the idea that doctors have special expertise at, for example, showing sympathy. And patients may well not be visiting the doctor for sympathy. But yet it seems clear that it is appropriate, and at the very least permissible, for doctors to show sympathy to patients during consultations. Moreover, as Murphy (2015) notes, it is in any case extremely difficult to delineate health vis-à-vis other kinds of human flourishing, so any attempt to restrict doctors’ work merely to improving health is unlikely to correspond with current practice and may have political implications – for example, the removal of family planning services from mainstream healthcare – which are unpalatable to many.

But reflecting on the specifics of my proposal again shows independently why these criticisms hold no sway here. Patients may not visit a doctor to learn about religion, but they implicitly solicit expert opinion on mental health, even when the advice may be unexpectedly personal. This in mind, given that doctors (and especially psychiatrists) are indeed well placed to know that religion may have a beneficial effect on mental health, there is no reason why my proposal should be seen as an illicit pretence to expertise. And given the implicit

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10 Murphy also notes that some work doctors do is not to do with the treatment or prevention of disease at all, for example, when prescribing contraception.

11 As, for example, when smoking parents are told, unexpectedly, that they ought stop smoking if they want to help improve their young child’s respiratory health, or that they should discharge the family pet if they want to avoid a severe allergic reaction.
solicitation for mental health advice, information about religion improving mental health is no less solicited than is the suggestion of an antidepressant with which a patient may previously have been unfamiliar.

4. Neutrality in medicine

Finally, it may be objected that medicine should be value-neutral, or at the very least religion-neutral. Even if we restrict the discussion to informing patients about religious engagement as opposed to recommending religious engagement, this may be taken as an implicit recommendation of religion, or it may indirectly prioritise some religions over others – since, for example, non-mainstream spirituality is associated with poorer mental health.

It is neither plausible nor current practice to treat medicine as value-neutral. ‘Best interests’ decisions are made frequently with respect to an implied shared set of societal values; certain cognitions (e.g. self-critical ones in schizophrenia, depression or anorexia nervosa) are deemed to be unhealthy and to be rejected and treated; female genital mutilation is to be reported, condemned and prevented; children are taken away from parents when it is judged (rarely) that the living arrangement is not a suitable one, to identify just a few examples. More generally, what constitutes ‘health’ must be decided with respect to certain value judgments: if, for example, there is nothing really wrong with messianic delusions or agitation in patients with dementia, it is difficult to justify treating them without patient consent. This latter point highlights the fact that medicine is not religion-neutral, either: believing that one is the messiah is a religious belief, and it is one which is routinely disregarded and treated (albeit sensitively and politely) without patient consent, using antipsychotics.

I cannot here advance a theory of when and which values and religious beliefs medicine should utilise or contravene. I note simply that medicine is not entirely value- or religion-neutral, and the examples given serve to justify this status quo. So any plausible version of this objection would need to be more specific about how medicine should be neutral. I know of no such objection. Medicine is not value-neutral, it is not evidence-neutral, and it is not religion-neutral. And it is all the better for those.

More saliently, I note for a final time how the detail of my proposal renders this objection obsolete. For in the absence of a recommendation of religious engagement, mere information implies no value judgment whatsoever. It merely gives the patients the empirical facts, according to which they can decide according to their own value system whether the facts constitute sufficient reason to pursue a management option. This is par for the course in medicine: doctors tell patients that smoking will harm their lungs, that promiscuous sexual activity increase their risk of sexually transmitted diseases, and that continuing a certain pregnancy carries a significant risk of early infant death. It is then the patient’s choice how to weigh up the medical advice within their own value system. The fact that some medical options may be offensive to the patient (for example, the option of terminating a pregnancy) is not ordinarily a reason to withhold the relevant information from the patient. Nor should it be in this case.
Conclusion

Some fellow clinicians have reacted to my thesis with bemusement, as they regard it as trivially true and uninteresting. But given that many doctors still feel uncomfortable informing patients in the way I have described, this is all the more reason for formalising its permissibility. Indeed, as plausible as my thesis is to some, I suspect it will be met with considerable resistance by others, perhaps along the lines of the objections I have considered. I will be grateful to receive such feedback and adjust or abandon my argument accordingly. I regret that I have not had space to deal with all possible objections – I appreciate that there is more to say and hope to say it elsewhere.

If one does think my thesis is trivial, then for the sake of academic interest I invite readers to work out the extensions of my argument to which I alluded earlier – for example, its implications for prayer in medical consultations. My argument provides some support for various other ways of integrating religion into psychiatry and, as I intimated, some support for the stronger thesis that clinicians should be obliged to inform patients of the relevant facts laid out here. I leave these extensions, however, as exercises for the reader.

Bibliography


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Spirituality and narrative in psychiatric practice: stories of mind and soul

by Christopher C. H. Cook, Andrew Powell and Andrew Sims

RCPsych Publications, 2016, 204 pp., £30 (pbk), ISBN: 9781909726451

This book has a relatively uninspiring cover and is hugely overpriced, but please do not let these put you off for it is a great banquet of a book, richly varied, tasty and, for the most part, deeply satisfying. Some readers might, like me, find some chapters slightly dry, technical and ‘worthy’ (even preachy), others more succulent and meaty, and yet others delightfully delicate in flavour while remaining full of sustenance. Whatever your taste, this book forms the ideal companion to the 2009 volume Spirituality and Psychiatry by the same editors and publisher. As the title suggests, it is full of stories and, because (as I have written elsewhere), ‘Spirituality is where the deeply personal meets the universal’, they are emotional, stirring, uplifting, sometimes tragic stories, not only touching everyone’s heart but also making us think. Perfect! The Contents page and Editor’s Preface set out the menu, fourteen chapters of which the last is a recapitulation and final commentary of what has gone before. In the first, Chris Cook describes storytelling as ‘a fundamentally human activity’ before clarifying that ‘narrative’ is the preferred term for professionals and academics, even at the risk of sounding too technical. Useful narratives are coherent, engage narrator and listener together, and invite interpretation. Giving more than simply the facts, they involve characters and relationships, thus providing, ‘A holistic and patient-centred approach to clinical problems, identifying diagnostic and therapeutic possibilities’. The idea of ‘spiritual’ narratives is defended with reference to notions of a quest for meaning and purpose, also of recovery following a transformative journey through adversity, often enabled or assisted by some form of deeply personal relation-ship with the sacred, whatever that may mean to the individual, possibly in the context of religious faith and
practice, but not necessarily. Finally, there is a warning: ‘Narratives can be harmful as well as helpful’. All these themes are repeated and developed elsewhere throughout the book.

So much for the taster! As a proper starter, Simon Dein writes next on ‘Spirituality and Transcultural Narratives’, offering comparable stories of people with mental health problems from Islamic, Jewish and Christian backgrounds, disentangling the specifically religious from the more universal aspects of each case, speaking of the challenge for professionals to reconcile the religious and bio-medical narratives, also the advisability of employing religious professionals as ‘culture-brokers’.

A second starter is Andrew Sims’s chapter, ‘Psychopathology and the clinical story’, introducing the idea that ‘Descriptive phenomenology aims to achieve understanding by looking at the subjective experience, the personal meaning of thought and behaviour of the subject’. Sims then makes clear the importance of empathy, of listening, persistent and knowledgeable questioning, and of feeding back responses until the patient accepts the description of the experiences under scrutiny. This is all a preamble to valuable sections – with illustrative stories – on ‘distinguishing spiritual/religious experiences from psychiatric symptoms’, ‘religious psycho-pathology’, ‘the phenomenology of faith’, and ‘phenomenology with spirituality’. His vignette of ‘Lucy’ demonstrates that in some patients, religious faith and experiences can live side by side with mental illness, in this case bipolar disorder.

There is one more general introductory chapter, one more starter, before we reach the main course: Andrew Powell on ‘Helping patients tell their story: narratives of body, mind and soul’. His aim, once again, like that of the whole book, is, ‘To show how, across a wide range of clinical objectives, paying attention to narrative is important both for diagnosis and for treatment’. In addition, he writes, ‘Transcending the limitations of the mundane life, soul wisdom brings a deeper understanding to the human predicament’. Calling for authenticity, Powell calls the narrative ‘an act of co-creation’ between people meeting on the basis of equality as human beings. Boldly, he states a major problem, that ‘mental health services provide little by way of
spiritedly informed care’. ‘Consequently’, he adds, ‘There is no way of knowing how often a transient psychotic episode might otherwise have become the turning point on a new path of meaning and purpose had the narrative only been explored in a different way.’ In this same section he asserts vigorously that, ‘Conflict, loss and soul-searching are implicated in most mental breakdowns. Body, mind and soul, whose interweaving remains the greatest conundrum in psychiatry, have to be taken together if the psychiatrist is to help the patient recover from breakdown to wholeness of being’. The remaining authors offer examples of good practice and show in different circumstances how this may be achieved, together with some of the pitfalls.

In chapter 5, authors James Lomax and Kenneth Pargament are more hopeful, writing, ‘Practitioners are just beginning to attend to the spiritual dimension of patients’ lives’. With the help of two extended clinical narratives (‘Sylvia’ and ‘Arnold’), which give a good idea of what it might have been like to sit in the therapist’s chair in their company, they focus on a range of ‘religious and spiritual struggles’ often associated with poor mental and physical health (with the divine, with the demonic, moral, interpersonal and doubt-related struggles, and struggles of ultimate meaning), also with a number of effective methods of ‘spiritual coping’.

For my taste, Frederic Craigie’s chapter, ‘Stories of joy and sorrow: spirituality and affective disorder’, was a favourite (along with chapters 8, 10 and 11). It began with an engaging story, followed by a brief review of the relevant literature, then some ‘approaches and examples of narrative-based, spiritually informed clinical care’. The stories mentioned included those of resilience, presence, connectedness, forgiveness, hope and joy. One patient, for example, went away from treatment ‘just feeling loved’. Another, remembering little of what the psychiatrist actually said, felt better because, ‘She really seemed to believe in me’. Recurring and helpful themes in treatment were those of ‘purpose’ (living faithful to deeply important personal values) and of ‘transcendence’ (letting go of unchangeable outer and inner experiences), complementary elements of change and healing. Craigie suggests that simply ‘inviting people to talk about the things they really care about’ may be all that is needed, both to provide direction and to
bring energy into the consulting room, thus enabling change to happen. What we care deeply about, in other words, is what we also hold sacred. This is a very rich chapter. In contrast, I found Chris Williams’s chapter, ‘Stories of fear: spirituality and anxiety disorders’, disappointing, not for what it included, but for what it left out. ‘This chapter,’ Williams writes, ‘describes how CBT [cognitive behavioural therapy] can be used to make sense of some very different personal responses to a mental health crisis’; and so it does, using the narrative examples of ‘Farah’ (a Muslim), ‘Daniel’ (an Orthodox Jew), and ‘Helen’ (a Christian). We are told that spiritual/faith aspects of a person’s problems ‘can readily be incorporated into CBT because they can be construed in terms of three key elements of beliefs, behaviour and relation-ships’. But where is there any recognition by the therapist of the whole authentic being and life journey of the patient? Where is any reference to mindfulness, (originally adapted by Jon Kabat-Zinn and colleagues in Massachusetts from Buddhist meditation techniques) that is so frequently and usefully an adjunct of CBT? Not in this chapter, I’m afraid.

My appetite returned again soon, however, with Gwen Adshead’s chapter, ‘Stories of transgression: narrative therapy with offenders’. Mentioning ‘the patients I work with’ (perpetrators of homicide and child abuse, who have given her permission to use their anonymous stories), she writes with remarkable coherence and exemplary compassion, not only for her patients and colleagues, but also for her readers, taking considerable pains to elucidate her highly complex, troubled and troubling field of interest. I liked, for example, her clarifying distinction between ‘resisters’ (who avoid responsibility for their destructive thoughts and actions) and ‘desisters’ (who ‘desist’ from further criminality by accepting a narrative emphasizing a sense that their previous offending did not represent their real nature, the true self they now sought to become). This is a fascinating chapter.

‘Even the darkest times can herald transformation.’ This is the theme of chapter 9, ‘Narratives of transformation and psychosis’ written by Isobel Clarke with the help of three people involved in developing and running, or in close sympathy with, the Spiritual Crisis Network. Katie Mottram, Satyin (Jim) Taylor and Hilary Pegg tell their own brave
stories of major breakdowns involving psychiatric services, with diagnoses including schizophrenia and bipolar disorder. ‘All three ... regard their experiences as ultimately narratives of transformation rather than narratives of illness,’ writes Clarke, who makes sense of these experiences in terms of research into ‘schizotypy’, which here means ‘ease of access to “non-ordinary experiencing”’. The chapter includes several suggestions for professionals assisting the transformative journey of people with psychosis in routine mental health care. In summary, she advises us to: (a) respect the experience with an open mind; (b) recognize the feeling as real, even when the story is suspect; (c) consider what might best motivate the person to re-join the rest of us in the shared world of everyday reality; (d) see the person as on a journey, perhaps into darkness and confusion, from which they have the potential to emerge stronger.

These points carry over well into the following chapter by Jo Barber, ‘My story: a spiritual narrative’, which is another courageous and ultimately hopeful personal account of prolonged, at times highly debilitating mental illness. By her own admission it is the story of a shy, obsessively studying teenager, terrified of failure, a confused, guilt-ridden, lonely and struggling student, later a mute, motionless patient on a psychiatric ward, a mental health service-user for 30 years, who is now a published researcher responsible for the Handbook of Spiritual Care in Mental Illness, and ‘a person coping independently, doing voluntary work, feeling fulfilled and happy for the first time in life’. It is well and straightforwardly-written, without pathos or drama, encouraging and instructive. It is satisfying, for example, to read,

Many people have helped me on this journey. My consultant provided acceptance, understanding, encouragement, crucial support and insight. The chaplain has helped me sort out what I really believe and why. And there have been other people, psychiatric nurses, a psychologist, people I have met through my work and, more recently, people from the church.

It is satisfying, but it reminds us too of our spiritually supportive duties as mental health professionals. Listen as Barber concludes her story:
'Telling your spiritual narrative is often therapeutic in itself and I believe that this opportunity should be available for all as part of routine spiritual care’.

If there is a dessert course to this gala dinner of a book, it is surely here in another of my favourites, Beaumont Stevenson’s chapter, ‘God’s story revealed in the human story’. Stevenson gives us a personal account of his developing faith to explain what ‘spirituality’ means to him, following this with ‘Spiritual narratives in a mental health community’ from his time as an Anglican chaplain in a psychiatric hospital. The stories are both serious and light-hearted. A patient feeling unworthy during a communion service accepts a Polo mint from her neighbour instead of a wafer from the priest, but the following week – to general applause – takes the wafer. Stevenson elaborates on the ways in which spiritual narratives heal, by means of metaphor and symbol, by promoting ‘living in the eternal now’, by ‘writing a new story’, ‘reframing the delusional’, ‘transforming the I-it into an I-Thou’ (some kind of healing relationship with the divine), and, ‘finding a place for suffering’. The stories of a patient claiming to be Jesus confronted with a chaplain saying he is Moses, and of his moving encounter with a patient in conversation with a lamp post, are priceless. Stevenson’s gentle, humble and wise words reveal the value of humour, kindness and simplicity. Although understated, it is clear that in his case these spiritual attributes are grounded in faith.

The chapter by the usually clear and reliable Jeremy Holmes, ‘Meaning without believing: attachment theory, mentalisation and the spiritual dimension of analytical psychotherapy’, could hardly be more different and was, for me, a second disappointment. There are some good bits, but the chapter as a whole comes across finally as too chewy and indigestible, perhaps best left on the side of the plate. Calling himself an ‘agnostic atheist’, Holmes takes on the theologian (and former Archbishop) Rowan Williams in what seems like an attempt to validate a kind of secular spirituality. Even after two careful readings, I failed to follow the argument precisely, but he does agree that the therapist’s task is to help counter ‘trauma, loss, hate, envy and destructiveness’, acknowledging that most major religions helpfully foster love, awe, forgiveness, compassion and gratitude, and are therefore on the same
side. The somewhat technical languages of ‘attachment theory’ and ‘mentalisation’ are recruited by Holmes, in an attempted fit with the more poetic and metaphorical languages of both Christianity and Buddhism, to argue for ‘a spiritual dimension to psychological health’, which ‘manifests itself in the inner narratives that emerge in successful psychotherapy’. Bravo!

By comparison, chapter 13 by John Wattis and Steven Curran, ‘Stories of living with loss: spirituality and ageing’, is far less convoluted. The issues regarding older patients are similar to those discussed elsewhere in the book, the emphasis being on the multiplicity of losses the ageing face and their shorter remaining time-span, plus the question, ‘What do they think will happen to them after death?’ The stories of ‘Jean’, ‘Maureen’, ‘Janet’, ‘David’ and ‘Ibrahim’ read well and are usefully illustrative of the spiritual aspects. The story of ‘Margaret’ and ‘George’, a couple in their 70s coping with George’s dementia, serves the added purpose of demonstrating how intimately affected a person may be by loss sustained by the other, while also focusing on specific issues relating to dementia. The authors tell us hopefully that, ‘Most old people cope with remarkable resilience, often based on a lifelong narrative of successfully coping with change and loss’. They remind us of the value of mental health professionals working together, and doing so ‘in a spiritually competent way’ in what is ‘an essentially spiritual task’.

As mentioned, the final chapter by the editors, ‘Beginnings and endings’, includes a general summary and a few useful final comments, for example that ‘listening takes time’, which may be in short supply in an increasingly pressurized and closely governed health service. ‘Many psychiatrists’, we are also warned, ‘will be sceptical of the views expressed in places throughout the book’. I agree, but this is no bad thing. Some chapters are so well-written as to engage meaningfully those with doubts, and if not persuade them, then at least encourage them to think these important issues through once more from a broader and more generous perspective.

The editors also remind us in this final chapter to listen for what people leave out of their narratives as well as what they include, and this
encourages me to mention one complete omission: there is no mention of the spirituality of children and adolescents, an important topic that would surely merit a chapter of its own. I have already said that I would have liked to see more too about the narrative and place of ‘mindfulness’ in the lives of patients and professionals. And in this context, I would have liked to read more about the vocational spiritual path of those drawn to serve people with mental health problems and how their work offers them opportunities to grow wiser and more compassionate in the helping of others through adversity, how it may form, in other words, a major part of their own spiritual narrative and journey.

The final omission to mention, rather a missed opportunity, concerns something implicit in the book but made explicit only briefly, towards the end of Lomax and Pargament’s thoughtful chapter (5). This concerns ‘the steps needed for this nascent area of practice to advance’, including particularly: more knowledge (different types of research), more training, and more narratives of the kind found throughout this book. These three linked facets all deserve considerable emphasis. Despite these few quibbles, I earnestly applaud all the authors and editors, who are to be thanked and congratulated for a magnificent slice of real life at the sharp end – where it truly hurts, but where it can also be healed.

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Taylor and Francis http://www.tandfonline.com/
Much Ado About Something: A Vision of Christian Maturity

by Dr Larry Culliford


In this engaging and accessible book, Larry Culliford offers a rich review of the nature of personal spiritual growth, from a specific but not narrow viewpoint. In his previous work, the author has primarily considered spirituality in psychological, health and developmental contexts, but here he brings his insights firmly into the Christian milieu, exploring them from the standpoint of his own faith.

In a world where some Western theologians and policy-makers have a tendency to elide ‘faith’ and ‘Christianity’ to a point where propositions become impossible to follow; and others assume that the census figures indicate the death of Christianity and hence of all religious practice, Culliford’s approach is refreshing. He acknowledges without regret or triumph the continuing hegemony of the Christian heritage in the common life of the nation, and recognizes the flourishing of other major faith traditions as equally important in formulating any arguments about individual spiritual development.

Culliford’s view of spiritual growth starts with a review of the way in which the left and right sides of the brain function and interact, to produce respectively a ‘persona’ or constructed identity that can cope with the everyday demands of life, and a ‘spiritual self’, the true person. The two are placed in tension with one another as the former clings to ‘attachments’ and ‘aversions’ while the latter seeks to break these bonds. Culliford creates a model that he calls ‘the arc of life’, covering six stages of spiritual development after infancy: egocentric, conditioning, conformist, individual, integration and universal. The universal stage produces the ‘enlightened self’ or ‘full spiritual maturity’. Underlying the arc is a baseline, the ‘spiritual self’ from which the arc moves away to its highest point, the time at which worldly ambition, attachments and aversions are at their strongest, and then may return fully or partially to its baseline depending on the stage of maturity reached.

Following the Wordsworthian idea of the child as ‘pristine’, Culliford sees this in Christian terms: the infant is born ‘imbued with the Holy Spirit’, with a need to return to this state, and a necessity of moving through the stages of the ‘arc’ in order to do so: these stages are described in the subsequent chapters of the book.

The ‘arc of life’ can present quite a difficult concept, in that authors such as James Woodward and Keith Albans, contemplating the spiritual life of older people, have seen spiritual development as an trajectory that continues upward when the health of mind and body have already peaked and are in a downward decline. Culliford’s ‘peak’, in contrast, is the point of least spiritual awareness and the ‘separation of flesh and spirit’ (p.76), and the second half of his arc represents the return to ‘enduring satisfaction’
However, Culliford would, I think, be in agreement with these experts on ageing that people can get ‘stuck’ at various stages of maturity if they cannot move beyond conformity, or do not have the opportunity or capacity to explore the ‘sense of purpose and meaning in life’ (p.84).

One of the many fascinating insights the author offers, is that of the ambiguous role of the church in promoting spiritual maturity. He proposes that the church can in fact let down older people by encouraging the tasks associated with the first half of life, and not ‘promot[ing] spiritual enquiry and development’ (p.123) needed in the ‘more holistic second half’ (ibid). Worship and faith remain important, but ‘we have somehow to relinquish … even religious attachments and aversions’ (p.203). Failure to do so leads to the mindset of Crusaders and Jihadis, stuck in ‘conformity’ and unable to exercise the tolerance that brings people closer to a loving God.

Culliford’s book is centred on the personal journey to spiritual fulfilment, and in particular on achieving this through Christian belief, contemplation, catharsis and ‘lysis’ from bonds of attachment. He does not explore as fully as one may have hoped, the role of relationships in finding meaning and peace, in spite of ‘love’ being a major theme in the book. My own work in the field of spirituality and older people indicates that it is frequently relationships with family, friends, carers and the community that enable discussion, exploration, reconciliation and ultimately spiritual contentment. Culliford suggests that the move towards spiritual maturity is followed by improved relationships, but as relationships also play their part, perhaps this should rather be seen as an iterative process.

Similarly. Culliford’s focus on ‘turnaround’, to which a chapter is devoted, gives possibly undue emphasis to his theory that ‘something happens’ to move people towards spiritual maturity; he also calls this an ‘awakening’ due to a ‘shock’ (p.148) that promotes lysis and catharsis. While this may well happen in some cases, and the author gives several examples, recorded conversations with older people suggest that it is also possible to move gently and gradually towards spiritual fulfilment, as life presents more time for reflection and losses become, if no less sad, accepted with greater resignation.

References to ‘love’, as already mentioned, provide a leitmotif throughout the book, although the author never quite defines the love that he posits as the most important part of humanity, Christianity and faith. The title of the book is a reference to the dissonance between, and eventual resolution through love for Beatrice and Benedick in Shakespeare’s Much Ado About Nothing.

Culliford explores the importance of love throughout, quoting Teilhard de Chardin: ‘Love alone is capable of uniting living beings in such a way as to complete and fulfil them’ (p.70). He contrasts ‘true, selfless love’ with the emotions that can distort it such as ‘sexual attraction, dependency and possessiveness’ (p.80) (although the first of these was surely a factor for Beatrice and Benedick?). Later, he talks of the maternal bond as ‘one of the purest examples of love’ (p.90), and the ‘true nature of God’ as ‘love’ (p. 99).
Perhaps it does not matter too much that Culliford does not discern or distinguish among these different expressions of love, but one is left with the feeling that he has somehow judged between them, though less certain of his verdict.

For myself, as an inter-faith practitioner, some of the most interesting and valuable insights offered by Culliford are those pertaining to the relationships between faiths and spirituality, from a Christian perspective. It is, again, the theme and prism of love that leads to these insights. Because ‘the nature of God is love’, and ‘love breeds … acceptance … rather than conflict’, it so follows that ‘partisan theologies and ideologies are … a mark of spiritual immaturity’ (p. 99). This observation refers back to the nature of the divided brain: the left side concerned with dualities such as ‘black/white, right/wrong, either/or’; while the right side sees the ‘both/and’, the unitary, holistic and spiritually mature picture. Culliford quotes from Romans 10.12: ‘the same Lord is the Lord of all, and is generous to all who call on Him’. So, while the book is avowedly Christian-centric, Culliford nevertheless recognizes the dangers of exclusive thinking. When Christianity (and by implication any faith) ‘becomes rigid and inflexible, and claims of superiority are made, the preconditions of division and conflict are met’ (p. 123); ‘the time has passed for any group to claim privileged knowledge’ (p. 124).

This rejection of religious exclusivity forms an important part of the author’s argument for spiritual maturity, as without it we will be unable to benefit from the transformational insights offered by all the great faith traditions, in particular the ‘enrichment’ of the Eastern faiths, which are more holistic in nature. In making this assertion, and throughout the book, Culliford acknowledges the profound influence of Thomas Merton, who described his own struggle to move on from ‘individuality’ and who also experienced and wrote of different religious and spiritual practices, and how they amplified his Christianity.

The problem with a book rich in ideas is that the author may choose not to explore them all, and the lack I felt most — although it had not in fairness been promised — was any exploration of shared spiritual life. There are references to Jung’s theory of the ‘collective unconscious’, and also to the collective spirituality of tribes, but the latter are seen to have reached the ‘conformity’ stage with no need to move beyond this as they are ‘as spiritually mature as their society require[s]’ (p. 117).

Culliford does, temptingly, allude to the interplay between spiritual inhibition at an early stage of the ‘arc’ and world problems. For example, totalitarian and fundamentalist regimes and all their concomitant horrors, are explained in terms of the ‘egocentric stage’ leader and the ‘conformist stage’ followers (p. 111). However, Culliford primarily equates spiritual maturity with the drive to benefit others and ‘contribute to mankind’s spiritual evolution’ (p. 171) on an individual basis, for example as a doctor, social worker or pastor. In fact, the author says of this final stage of the arc, ‘A desire for things (and for things to be different) fades, contentment with what is (and the way things are) remains’ (p. 170).

Where does this leave us as citizens of the world? Should we not be making pilgrimages to protest against climate change, or encouraging our governments to be more compassionate? Culliford says, ‘As individuals we can do little to prevent catastrophe, to make spiritual development happen at the wider cultural level … except by taking care of
our own personal development’ (p. 202). I would so like to see him produce further work that explores the interplay between the personal and the public in spiritual terms.

In summary, *Much Ado About Something* is informative, enlightening and a pleasure to read; the fact that it raises more questions than it pursues could be seen either as a merit or a fault — depending on Culliford’s future plans.

The clarity of approach in this book and the implications of the author’s ideas for personal and social well-being should attract a readership that includes those seeking insights into their own spiritual life; those with an interest in mental health, spirituality and the human brain; and those with pastoral roles, especially with older people.

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This book grew out of an eight week course developed by the authors called Kindness Behaviour Training (KBT). The course seeks to address what the authors identify as a missing element in the explosion of mindfulness courses, namely kindness. Kindness is defined as ‘the motivation for the well-being of oneself and other people, coupled with a willingness to act on that desire.’

Both authors have many years of clinical experience working within NHS mental health settings as well as rich experience of living within the Buddhist Triratna tradition. The combination of these experiences allows the authors to write with authority, warmth and wisdom about helping people from all walks of life cultivate kindness towards themselves and others.

As befits a course book, the book has a strong educational ethos, with a clear layout, guidance on how to use the book and numerous practical exercises to enable the reader to embody what the book is teaching. Like many good teachers the authors use multiple analogies to communicate their message. The overarching analogy for the book is one of cultivating the ‘garden of the mind’ to encourage the growth of kindness. The chapter headings make use of this analogy, e.g. ‘Preparing the earth’; ‘What about the weeds?’; ‘The finest flowers: gratitude and generosity’. Having more time to work in the garden following my recent retirement from the NHS, this analogy felt very resonant for me - but it may not work for every reader.

Each chapter begins with an apposite quote (the text is sprinkled with many inspirational quotes) and an ‘at a glance’ summary of the chapter. The text is clear and guides the reader through the practice of Mindfulness (Chapter 1); Working with our tendency to avoid pain (Chapter 2); Developing a meditation practice focussed on kindness (Chapters 3 and 4); Practical ways to develop gratitude and generosity (Chapter 5); To use our imagination (Chapter 6); To nurture our sense of our common humanity (Chapter 7); To forgive (Chapter 8). Each quality is clearly defined and explored. The authors give welcome attention to aspects of these qualities that may be given less
attention in comparable texts. For example, they highlight the value of beauty and the mutually reinforcing relationship between beauty and kindness. They also emphasise the importance of kindness and truthfulness in speech – a timely call in an era when there is so much false speech.

One of my initial reservations about the authors’ approach was the claim in the first chapter that the medium from which kindness grows is mindfulness. I see kindness more as an innate quality of the heart, growing out of what one might call ‘heartfulness’ rather than mindfulness. However, as I ventured deeper into the text, these initial reservations subsided. In the final chapter, the authors write of the importance of listening to our heart – the seat of our intuition - and provide a practical exercise to embody this. They quote the Sufi poet Rumi’s piercing observation that ‘Your task is not to seek for love but merely to seek and find all the barriers within yourself that you have built against it’. This is where mindfulness practice and all the related practices from other spiritual traditions are so helpful.

Overall, I enjoyed this book and continue to savour some of its pearls of wisdom. It has something to offer both ‘beginners’ and more seasoned practitioners of mindfulness as well as those from non-Buddhist traditions of contemplative practice. It could easily be used as a course book in a clinical setting.
Dealing with Religiosity and Spirituality in Psychiatry and Psychotherapy

Position Paper of the German DGPPN Task Force

(German Association for Psychiatry and Psychotherapy, Psychosomatics and Neurology)


Background

Cultural diversity is increasing in society, especially because of migration and the differentiation of social environments. Consequently, psychiatric-psychotherapeutic care of patients with diverse backgrounds has to be sensitive to cultural and religious factors (Kizilhan 2015). In the USA religious and spiritual competencies are already described for psychiatrists and psychotherapists (Morgan & Sandage 2016; Vieten et al. 2013). It is also the case in Germany that patients with mental illness expect their psychiatrists and psychotherapists to have a holistic perception of their life situation, including its existential, spiritual and religious dimensions (Best et al. 2015; Curlin et al. 2007; Huguelet et al. 2011; Lee et al. 2015). A recent exploratory study in Germany surveyed the significance of existential issues for coping with illness in 30 patients at a behavioural therapy outpatient clinic. It was found that directly addressing and immediately processing existential topics in therapy was relevant for treatment (Grober et al. 2016).

We encounter patients who believe in ghosts, pray compulsively, or have eschatological expectations. Practitioners who lack understanding for a patient’s cultural and religious characteristics risk unknowingly violating religion-specific taboos and boundaries. Therefore, at the point of psychiatric diagnosis, differential diagnosis and evaluation of medical history factors like religiosity and spirituality (R/S) should be considered. This attention to spiritual factors within psychiatric evaluation is necessary in particular with the following constellations: e.g. in patients showing suicidal tendencies, religious delusions, depressive guilt and post-traumatic disorders.

Clarification of terminology and connotations: Whereas the term religion generally refers to any religious community with its shared traditions of rituals and texts (e.g. Christianity, Judaism, Islam, Buddhism, Hinduism) religiosity refers to the personal aspects and life practice of religion beyond any institutional affiliation or ritual. Spirituality is often used as an umbrella term in health sciences. It refers to a personal search for the sacred, for connectedness or self-transcendence, which specifically includes worldviews outside of institutionalized religions (Bucher 2014; Pargament 2013). The term existential refers to boundary situations, to the experience of illness and death and its specific questions which might be crisis of meaning, reviewing one’s life, or transcendence (La Cour 2012; Schnell 2016).

The Islamist terrorist attacks on 9/11 in the USA caused a new, intense debate about the place of religion in modern society also among secular psychotherapists in Germany (Kühn et al. 2010). A constructive dialogue between religious and secular ways of meaning giving is needed in a pluralistic society. From a cultural science perspective, Straub (2016) recently

differentiated that in our time the conflict line that is mostly significant in society is no longer between religious believers and unbelievers, but between people who have reflected and integrated their worldview into their identity structure and those who have a totalitarian structure.

Meaning can be found through a secular or a religious-spiritual worldview. Meaning is built on interpretative components out of subjective values. Until now, these aspects have received too little attention in psychotherapy (Flassbeck & Keßler 2013; Frey 2016). Through the dissemination of mindfulness-based approaches psychiatrists and psychotherapists have started to reflect differently on psychotherapeutic values and their ethics (Grossman & Reddemann 2016). For the purpose of adequately addressing R/S the therapist’s values and basic assumptions as well as the implicitly mediated values within the respective psychotherapy should be reflected on.

Within the professional discussion on the inclusion of R/S in psychiatric-psychotherapeutic treatment one can find the following viewpoints: While some authors recommend spiritual treatment methods, i.e. the inclusion of R/S interventions on the basis of empirical evidence (Anderson et al. 2015); others, like the Austrian Ministry of Health warn against boundary transgressions and the abandonment of scientific standards and forbids esoteric content, spiritual rituals and religious methods in psychotherapy (Österreichisches Bundesgesundheitsministerium 2014). Because the assessment of R/S in psychiatry and psychotherapy is highly dependent on the cultural context, the DGPPN has set up a task force to create a position paper on R/S in psychiatry and psychotherapy and to promote a discussion on the topic within the German health care system. One aim of the position paper was to adopt the international discussion of this topic to the German situation. The composition of the Task Force ensures that it is balanced in terms of denomination/religion, cultural background, occupational groups and gender aspects.

Today the criticism and disease mongering of R/S, which prevailed in science in earlier years, is no longer appropriate. This critical attitude, however, should not be replaced indiscriminately by an idealization of the field. Psychiatry and psychotherapy can make an important professional contribution to the formulation of criteria for healing and harmful aspects of R/S.

**Basic assumptions**

- R/S are regarded as anthropological universals (Luckmann 2002; Meindl & Bucher 2015). Religiosity and spirituality are part of being human and should be acknowledged in the context of a holistic view – regardless of the possible influence of R/S on health outcomes (Koenig 2008, 2012) or on the efficiency of therapeutic interventions.

- R/S are identity-forming in both the patient and the psychiatrist/psychotherapist. This is evident especially in existential crises and boundary situations, but also in moments of purposefulness and life phases of existential indifference (Schnell 2016).

- In psychotherapy, R/S should be perceived and appreciated as personal systems of meaning and culture-forming influencing factors (Utsch et al. 2014). For reasons of professional ethics, psychiatrists and psychotherapists are obliged to respect their
patients regardless their age, sexual orientation, social position, nationality, ethnic origin, religion or political conviction.

Present research

When reviewing the English-language literature on the relationship between religiosity and psychotherapy (e.g. Anderson et al. 2015; Goncalves et al. 2015; Lim et al. 2014; Ross et al. 2015) it is noticeable that R/S is often seen as a modular component of psychotherapy itself (e.g. in the context of behaviour therapy [BT]/cognitive behaviour therapy [CBT]). Most of the research has been performed in the USA. As R/S can only be analyzed within the cultural context of individuals, the results cannot simply be transferred to the European situation; our own research is urgently needed in Europe to add to the small amount of European data. Unlike in the USA, in the German-speaking world there is a great deal of caution regarding spiritual interventions in psychotherapy. Exceptions can be found within Buddhist-meditative elements in mindfulness-based therapies (Anderssen-Reuster 2011; Anderssen-Reuster et al. 2013; Harrer & Weiss 2016).

A great deal of research exists, particularly from English-speaking countries, on the relationship between R/S and health (Koenig et al. 2012). Despite all the attention that many studies on spiritual interventions have paid to methodology, it is noticeable that the authors attribute the therapeutic effects to the impact of faith rather than to psychological mechanisms. Therein lies a fundamental bias. Criticism of this aspect has also been raised in the USA (Sloan 2006; Sloan et al. 2000). We therefore need psychiatric and psychological models of association to explain why R/S can act as a resource or a stress factor (Murken 1997; Schowalter & Murken 2003).

The risk of improper boundary transgression and encroaching behaviour by the therapist in spiritual psychotherapy modules is discussed more intensively in Europe than in the USA (Galanter et al. 1990). Even though the importance of existential issues is recognized in psychotherapy, some questions remain open. For example, is giving meaning the task of psychotherapeutic interventions (Hardt & Springer 2012)? How far the psychiatric-psychotherapeutic support of the patient can go in his or her existential, religious and spiritual search? What professional boundaries are necessary and meaningful to protect the freedom of the patient and the practitioner?

It is becoming clear that religious and spiritual topics in psychiatry and psychotherapy have not yet been adequately evaluated, researched and communicated in a training context. These factors are even more important because, besides the classical religions, a mushrooming psycho-spiritual counselling market has emerged that includes some questionable offerings (Brentrup & Kupitz 2015; Murken & Namini 2008). Quite a lot of patients are looking for a spiritual teacher – the guru question is an important subject in psychotherapy (Caplan 2011).

The many guidelines written specifically on R/S show the important role of R/S in English-speaking psychological and psychiatric professional associations (Cook 2013; Galanter et al. 1990; Moreira-Almeida et al. 2015; Peteet et al. 2006).

As people with mental illness often turn to the head of their religious community, the American Psychiatric Association (2016) has launched the “Mental Health and Faith
Community Partnership” and set up a working group which has written a guiding manual for the spiritual leaders and ministers of religious organisations on how to properly deal with mental illness.

The Section “Religion, Spirituality and Psychiatry” in the “World Psychiatric Association” (WPA) works on these issues and publishes its results on its own website as well as in a regular newsletter (WPA, 2015). Recently the WPA published a position paper on how to deal with R/S (Moreira-Almeida et al. 2015). As empirical evidence has shown, R/S affects the prevalence (especially of depression and dependence disorders), diagnosis (distinctions between spiritual experiences and mental illness) and treatment (inclusion of spiritual needs) of mental illnesses, the WPA recommends that its members pay greater attention to these issues.

Over the last 15 years the American Psychological Association (APA) has published over a dozen textbooks on the psychology of R/S. It also publishes findings related to psychological aspects of religion and spirituality in the journal “Psychology of Religion and Spirituality.” In addition, two years ago the APA started publishing the quarterly journal “Spirituality in Clinical Practice,” which presents scientific reports of spiritually-oriented clinical interventions (http://www.apa.org/pubs/journals/scp). Pargament and colleagues (Pargament et al. 2013) have published a two-volume APA handbook that summarizes the current state of knowledge.

The British “Royal College of Psychiatrists” regularly offers further education on these issues through its special interest group “Psychiatry and Spirituality,” which now includes over 3,000 members. Materials and information about meetings are provided on a dedicated website (Royal College of Psychiatrists 2016). The group has presented a consensus paper on dealing with R/S (Cook 2013). This paper states that members are obliged to respect and be sensitive to the religious or spiritual affiliations of their patients. Clinicians should not offer religious or spiritual rituals as a substitute for professional treatment methods. On the other hand, attention is drawn to the role of positive spirituality in coping, which can be used to convey hope and meaning.

Similar initiatives are also currently being developed in Germany. Nevertheless, Germany has a great need to catch up on research, teaching, training and clinical work.

Recommendations of the DGPPN Task Force

1. **Intercultural competence.** Because culture influences R/S, a patient’s individual health and disease concepts should be explored in a way that is sensitive to culture and religion. This includes the ability of the therapist to change perspectives. The Cultural Formulation Interview (CFI), which was developed within the framework of the DSM-5 (APA 2013), has proven to be useful in this context. Culture- and language-related misunderstandings should be resolved.

2. **Spiritual history.** When taking the psychiatric-psychotherapeutic history, information on values and religious and spiritual convictions, rituals, affiliations and their relevance in the patient’s life should be recorded (Frick et al. 2002).
3. **R/S in the treatment plan.** The practitioner should be able to recognize R/S as a resource and/or stress factor for patients and, if necessary, to integrate it into the treatment strategy. This also is necessary if the practitioner is a religious or has a worldview different from the patient. Hence, the patient’s view of R/S and his or her respective valuations have to be understood and taken into account in the treatment plan. It is often necessary to examine existential questions even with patients without a religious/spiritual attachment. The acceptance of a patient’s R/S convictions may have to be limited if there is a risk to self or others.

4. **Boundary violations based on R/S motives.** The therapeutic relationship and therapeutic treatment in institutions requires clear rules. If these are broken because of religious or spiritual convictions (e.g. religious zealotry/fundamentalism), the patient has to be confronted with the applicable rules as part of the reality principle. Depending on the setting (clinic, inpatient acute psychiatry, practice, etc.), differentiated interventions are necessary to protect or re-establish boundaries.

5. **Professional boundaries.** Psychiatrists and psychotherapists have committed themselves through their professional ethics to work within the spectrum of methods of their profession. Therefore, religious or spiritual interventions are excluded. This exclusion is a meaningful and necessary self-limitation. It must nevertheless be ensured that therapy provides a space for the patient’s R/S. The Task Force considers it essential that German-speaking psychiatry and psychotherapy give greater consideration to R/S than heretofore.

6. **Diversity management.** Facing a vivant market of diverse psychospiritual offerings and their sometimes questionable promises and framework conditions, the task force recommends that the ideological background of a healing method should be transparent, that professional and scientific standards should be maintained and that an approach should be taken that is sensitive to culture and religion.

7. **Neutrality.** The practitioner should remain religiously neutral in a respectful way but be open to a possible transcendence as it relates to the patient. A distinction should be made between psychiatric and psychotherapeutic treatments on the one hand and pastoral care and spiritual guidance on the other. Both should remain separate. In many cases, however, collaboration in the interest of the patient can be useful. For this purpose it is helpful if chaplains improve their basic knowledge about psychiatry and psychotherapy.

8. **Basis in the therapeutic relationship.** The question of the interaction and fit between the patient’s and practitioner’s basic attitudes towards R/S are to be reflected on in self-exploration. The prerequisite for this reflection is that psychiatrists and psychotherapists know and critically reflect on their own worldview. The phenomena of transference and countertransference are particularly important in the context of R/S. During reflection, self-exploration and supervision special consideration must be given to the area of tension between the ideological neutrality and religious or spiritual self-declaration of the psychiatrist and psychotherapist as well as questions of truth and values.
9. **Training, further education and continuing education.** Psychiatric, psychotherapeutic and psychosomatic training, advanced training and continuing education must be improved both in terms of the basic knowledge of religious and worldview questions and in particular with regard to opportunities for self-exploration. Competencies in R/S-related attitudes, knowledge and skills should be trained and developed. Corresponding learning goals should be integrated into medical training and further education regulations.

10. **Research.** Research on the significance of world views and of models for giving meaning as a burden and resource in the German-speaking world is useful and necessary. An interdisciplinary dialogue between psychology of religion, theology and psychiatry, psychotherapy and psychosomatics is desirable and necessary. The following research topics appear to be important, among others: (1) perception of patients’ R/S needs, (2) R/S as a barrier to treatment and (3) cooperation between health professions and pastoral care offerings.

**References**


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