

Mysterious ways:

Spirituality and British psychiatry in the 20th century.

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Abstract

Changing attitudes towards faith, religion and spirituality within the establishment of British psychiatry over the last 50 years are a reminder of Cowper's lines: 'God moves in a mysterious way His wonders to perform'.

This is a subjective account of changing attitudes towards spirituality in British psychiatry in the last century, especially the second half. There will be comment upon the influences on psychiatry in the first half of the century.

By 1950, psychiatry viewed the spiritual concerns of patients, and religious faith of psychiatrists and patients, with suspicion and often hostility. Psychiatrists sometimes believed that religion was 'bad for your health'. The Church distrusted psychiatry for 'leading people astray'.

In the 1960s, religious feeling was often equated with neuroticism. The patient's religious beliefs were not regarded as important, and there was little attempt at collaboration between psychiatrists and religious leaders to help patients.

In the 1970s some people becoming consultants started to discuss the relationship between their Christian faith and their practice as psychiatrists.

During the 1980s there was increasing confidence by this small minority in marking out legitimate territory for the overlap between religious faith and psychiatric symptoms, and some meetings took place.

Quiet progress of previous decades became more public in the 90s, with the address of the Patron of the College in 1991, and of the Archbishop of Canterbury in 1995. Biennial conferences of religion and psychiatry also took place. There was an increase of research in this area.

There have been massive changes in attitude in the last 50 years. The culmination of these developments during the last century was the founding of the Spirituality and Psychiatry Special Interest Group at the very beginning of the new millennium.

Introduction

My own understanding of theology, which I come to from Christianity, is the absolute centrality of relationship in the whole of creation. As the fostering of healthy relationships is also fundamental to psychiatry, one might have thought that the two, religious faith and psychiatry, would, historically, work together. This has not been so.

There is no such thing as objective history. This paper is the story of what I observed and experienced as a participant, a laboratory animal, not an Olympian outsider. You may disagree with my inferences - but that is how I saw it, at least over the last forty years.

My own life seems to have fallen roughly into decades, and therefore that is the way I will describe my observations. I will mention the following:

- The relevance of William Cowper for this story;
- Influences on British psychiatry in the area of faith, spirituality and religion up to 1950
- The 'spiritual' history of psychiatry in Britain
- 1950s / 1960s / 1970s / 1980s / 1990s / 2000
- Conclusions: what do we learn?

William Cowper 1731-1800

Why do I quote William Cowper in the title of this paper? He was a century away from our material, and what had he to do with psychiatry? In my opinion, Cowper's words describe the situation within psychiatry over the last 50 years rather well 'God moves in a mysterious way His wonders to perform.

William Cowper was a well-known English poet in the 18th century, probably more quoted than Betjeman in the 20th (Davies, 2001). He was a deeply committed Christian, and wrote a number of well-known hymns, from one of which comes this quotation. He also suffered from a clear-cut bipolar affective disorder with both manic episodes and several psychotic depressive episodes. During a manic episode he was described as being 'too happy to sleep', and the poem: 'John Gilpin was a citizen of credit and renown ...' was also written in a state of elation. During an episode of very severe depression as a young man before he discovered his religious faith, he made several attempts at suicide on the same day. In later life he had delusions of guilt and damnation when severely depressed (Sims, 2003):

'Hatred and vengeance, - my eternal portion,
Scarce can endure delay of execution, -
Wait with impatient readiness to seize my
Soul in a moment'.

It is not surprising, therefore, that psychiatrists who regard the spiritual dimension as important are intrigued by Cowper's life.

The influences on British psychiatry in the first half of the 20th century

European psychiatry in the first half of the 20th century was, of course, the product of its history. From the time of Vives, a contemporary of Galileo's, and who like him, although being a devout believer, found himself in conflict with the monolithic ecclesiastical establishment of the counter-reformation, the roots of psychiatry have been more than tinged with anti-clericalism, although not atheism early on. This had a powerful effect upon the mutual suspicion that later developed between the Church, as an institution, and psychiatry.

Kathleen Jones (1991) has written about the mental hospitals in Britain: 'In the second half of the 20th century, the mental hospital system, once so solid and seemingly impregnable, has virtually collapsed'. The first county asylums had been set up in the early 1800s, rapid growth continued throughout the rest of the century, by which time 74,000 people were resident in asylums. The number continued to increase, reaching 140,000 by 1930. In the first half of the 20th century, psychiatry was dominated by the asylum system. This influenced the thinking of all psychiatrists, and those contemplating joining the specialty. Asylums were, for psychiatrists, a challenge to manage well, but also a source of embarrassment and dislike. Whilst the Victorian institutions all had their chapels, by 1950 many psychiatrists wanted to play this down and convert them into another use.

With the enormous development of science, and the espousal of modernism in philosophy, reductionism dominated medicine in the first half of the twentieth century. Man was 'nothing but' an excessively cerebral erect ape; human behaviour was 'nothing but' Pavlovian conditional or Skinnerian operant conditional responses. When I read medicine at Cambridge in the '50s, comparative morphology was an important part of our anatomy course, and the implicit message was that most of our anatomical features and physiological processes could be traced to the lemur. Scientific psychiatry bought in wholesale from this approach.

Freud, in 'Moses and Monotheism' (1939), stated that belief in a single God is delusional. Psychoanalysis, although not taking over psychiatry in Britain as in the

USA, was intellectually fashionable in the 20s and 30s, and most exponents recognised conflict with traditional religious attitudes, both within the discipline and for individual patients. Many churches also identified Freud, psychoanalysis, and, by association, the whole of psychiatry, with atheism, antagonism to religion and a challenge to conventional morality.

In the first half of the 20th century, psychiatrists, especially those in teaching hospitals, were desperately anxious to achieve respectability. The few academic psychiatric units tended to receive their referrals from general practitioners and other hospital consultants and did not want to have anything to do with the mental hospitals. Some such psychiatrists never used the Mental Health Act throughout their career; it was as if their patients came from a different group than the denizens of the asylum. They were often the most reductionist of all consultants and applauded the drug era on philosophical as well as therapeutic grounds.

These attitudes had developed despite the Christian roots for the treatment of the mentally ill. Caring for the mentally ill began in the medieval monasteries, for example, Bethlem Hospital founded in the 13th century (Shorter, 1997). Thomas Guy, a Baptist publisher, established his eponymous hospital on Christian principles with a 'lunatic house' in 1726.

Conflict developed early on between psychiatry and the Church concerning both the causation of symptoms or unacceptable behaviour and the preferred approach for dealing with them. Psychiatrists regarded 'symptoms' to be manifestations of mental 'illness' requiring medical treatment; the Church saw madness as 'sin', evidence for the work of the Devil, or demons, and requiring exorcism, or at least penitence, for their deliverance.

Freud variously described religious belief as delusional or neurotic. Pavlov's work on conditional responses became the basis for Soviet atheistic psychology. Skinner's operant conditioning was essentially reductionist: reinforcement explains all human behaviour. Even drug treatment did not escape the conflict: 'pharmacology' comes from the Greek word, pharmakeia, which is the word used in the book of Revelation for 'sorcery'. Thus, the scene was set, by 1950, for mutual hostility and suspicion.

1950s

By 1950, psychiatry had achieved identity, although not unity, in Britain through being a medical specialty, and fully integrated within the newly instituted National Health Service (Webster, 1991). This ended years of administrative isolation from the rest of medicine, and was seen as highly significant for the discipline.

Spiritual concerns of patients were at best bracketed out as being outside the scope of psychiatry, and at worst challenged as being unhealthy, tending towards neurotic illness. Religious faith and practice of both patients and the psychiatrists themselves was largely ignored, but sometimes received disapproval. In general, psychiatrists treated 'religiousness' with suspicion and a degree of hostility. At this time the therapeutic effectiveness of psychiatry was very low.

As a result, the Church was distrustful towards psychiatry, regarding it as atheistic and amoral. Church members were often discouraged from consulting a psychiatrist, even when they were clearly suffering from a mental illness. This fear and suspicion carries over amongst some church people even to the present day. Psychiatrists considered that the teachings of churches could be causative of subsequent mental illness.

1960s

Little changed in this decade. The attitude of most in the psychiatric establishment towards all religion, and specifically towards Christian faith, was not neutral but hostile. Religious belief amongst patients was equated with neurosis and amongst trainees in psychiatry was regarded as being seriously unscientific and

strongly discouraged. This was my experience in the periphery. I checked it out with Dr Julian Candy, who was training then at St Thomas's and the Maudsley, and his experience, both then and later as a young consultant, was no different.

There were a few exceptions, brave pioneers, who tried to bridge the vast chasm that had opened up between psychiatry and faith. Respected psychiatrists who openly acknowledged their religious faith included Ian Lodge Patch and Jack Dominian in London, and Arthur Pool in Manchester. In Britain, Frank Lake had trained in psychiatry and wrote extensively, but he had more influence among clergy than psychiatrists. Paul Tournier, a generalist not a psychiatrist, writing in Switzerland, combined Biblical teaching with psychological insights in his clinical practice and his books. He inspired two generations of doctors, including me. We owe a considerable debt to these and others who confronted conventional dogmatism and took into consideration the spiritual concerns of patients.

When I entered psychiatry in the '60s, I knew of very few psychiatrists who admitted to being Christian. When I told a senior doctor, a surgeon, whom I knew that I intended to do psychiatry, he said 'that is no place for a Christian'!

Psychiatric textbooks of the time virtually ignored religion. As an example, the standard British textbook was Mayer-Gross, Slater, Roth, with 1st edition in 1954, 2nd 1960 and 3rd 1969. There are only two references to religion in the index: 'Religiosity in deteriorated epileptic', and 'Religious belief, neurotic search for'. The latter is an attack upon psychoanalysis but assumes religion is for 'the hesitant, the guilt-ridden, the excessively timid, those lacking clear convictions with which to face life'.

In the '60s there was no sense that the patient's religious beliefs were an important part of the psychiatric history, formulation and planning of treatment. Spiritual aspects of the patient's problem were usually ignored. A psychiatrist said to me: 'No patient has ever talked to me about religion'. In general, there was no sense that there could be collaboration between psychiatrists and religious leaders in the care of patients.

1970s

On this topic, this was a quiet decade. In medicine and science, there was increasing interest in aspects other than the material. The Scientific and Medical Network was set up in 1974, initially almost as an underground organisation, because even the notion of consciousness was unacceptable for many in the scientific establishment.

Those of us who wanted to work out the implications of our Christian belief for our work in psychiatry began to know of others who were similarly minded. A few of us had passed through the training grades and had become consultants. There were informal discussion groups, initially in London around Ian Lodge Patch, and later in Bristol, Nottingham, Leeds and elsewhere.

More practicing Christians began to come into the specialty - it was no longer taboo. Significantly, there was a considerable influx in this decade into psychiatry of those of other faiths, most having qualified in medicine in other countries. At first, they did not talk about their religious beliefs and implications for psychiatric practice, but latterly this has become a considerable influence.

There was still no change of attitude of the psychiatric establishment towards religious faith in patients. Typical was the practice of a consultant who saw depression everywhere, who never used any treatment but drugs and who could not tolerate explanations for illness other than the biological - a psychiatrist keeping at bay the demons within himself.

There was a vague notion that mirrored the developing *zeitgeist* of post-modernism that perhaps materialism 'had gone too far'. However, there was no very clear idea, either organisationally or individually, as to how this should be countered.

1980s

This was the decade in which like-minded people got together and discussed non-material, religious and spiritual issues. A number of informal groups were set up in different parts of the country and discussed matters of faith in relation to psychiatric practice. Christian churches were, in general, better disposed towards psychiatry, perhaps because treatment had become more effective, and more Christian trainees entered the specialty.

A considerable boost to the intellectual life of the College was the institution in 1988 of the Philosophy in Psychiatry Special Interest Group, and an early meeting of the Group was devoted to the topic of religion and psychiatry. This Group has, over the last 15 years, been a healthy antidote to excessively convergent thinking.

A loosely knit Association of Christian Psychiatrists was set up in the early '80s with a wide mailing list and occasional meetings. This has persisted but has not been very active recently.

The first Christian Medical Fellowship breakfast at a national meeting of the Royal College of Psychiatrists was held in Manchester in April 1986. It has continued annually ever since and has had talks of the highest calibre on subjects relating psychiatry and the practice of personal faith. Speakers have included distinguished non-psychiatrists such as Baroness Cox and Professor Peter Grey, and our own members such as Lord Alderdice, Professor Clifford Allwood of Johannesburg and Professor Patricia Casey. All the talks have been good and some have been outstanding; it has been encouraging that psychiatrists of other than Christian faith have felt comfortable in attending these events.

During this decade, psychiatrists with spiritual interests gained confidence in expressing their faith and working out the consequences for their professional practice. Religious belief was still not regarded as quite respectable by the rest of the profession but there was less animosity.

1990s

The quiet progress of the '70s and '80s became more public in the '90s. The importance of acknowledging spiritual needs in the life of our patients, and understanding them, was presented in an address to the College by our Patron in 1991 (HRH Prince of Wales, 1991). The need for more co-operation and mutual understanding between psychiatrists and church leaders for the benefit of those they were both trying to help was the message of an address to a joint meeting of the College and the Association of European Psychiatrists by the Archbishop of Canterbury (Carey, 1997). The importance of the religious dimension in a multicultural society was made at biennial Conferences of Religion and Psychiatry (Bhugra, 1996). In my valedictory lecture as President, I tried to emphasise the importance of the spiritual in 'psyche', and how this was significant for patients (Sims, 1994).

Over the decade attitudes of psychiatrists changed significantly. As a profession, we became more accepting of the spiritual and religious concerns of patients and more interested in the relationship between psychiatry and religion.

One practical consequence of this was a scheme over the country set up by St. Luke's Hospital for the Clergy whereby a psychiatrically ill clergy-person could be seen by a consultant psychiatrist from a neighbouring diocese. This has been of benefit to many clergy and brought goodwill to psychiatry.

Research in the area of mental illness and religious belief developed during this decade from almost zero - and what there was, rather unsophisticated - to an accepted research field with supportive funding. Larson, in the United States, carried out a large number of outcome studies before his premature death (McCullough, 2000); in this country King (2001) has been involved with developing an appropriate methodology.

2000

One could see the setting up of the Spirituality and Psychiatry Special Interest Group as the culmination of a half-century of hard-won progress. The first meeting of the group was in February 2000 under Dr Andrew Powell's inspired chairmanship. The response to setting up the Group was amazing with a large number of signatories and meetings over-subscribed. At an early meeting an elderly psychiatrist said: 'Throughout my career I have wanted something like this'.

Professor John Cox, in his valedictory address as President last year, stressed the importance of our work to be concerned with the whole person. Dr. Peter Fenwick has charted the significance of spirituality from the neuroscientific perspective.

Conclusions: What do we learn?

1. This has not been the triumph of the philosophical/ psychological over the scientific/ quantitative aspects of psychiatry. This would be grossly mistaken. Some of the most distinguished scientists in our discipline, as you will hear later (Fenwick, 2003), have been most active in promoting this change of attitude. Some psychological opinion has been hostile to the notion even of mind, let alone spirit or soul.
2. There should be no proselytising of patients; neither should there be denial of the patient's right to discuss his religious beliefs and their interconnection with his mental illness.
3. It is heartening that, looking at it over decades, shifts in attitude do occur. I suppose that one should not be surprised considering all the other changes of mores, zeitgeist and, most of all, technology that have occurred over the last 40 years.
4. Alliances have been forged between what superficially seem to be disparate groups of people: open-minded agnostics, committed Christians, Hindus, Muslims, Jews and Buddhists - some of whom have been born overseas. However, the individuals have found that what they hold in common about the primacy of spirit makes a valuable contribution to enriching their own professional lives.
5. This movement, and it is significant enough to be so designated, has benefited psychiatry. Patients are relieved to know that their rights and expectations to have all aspects of themselves as whole people have been acknowledged. There is a sense of liberation, coupled with more assiduous application to their profession, for psychiatrists to be able to use body, mind and spirit in their work with patients.
6. It is unlikely that psychiatrists now record a higher church attendance than they did in 1950. However, some with dormant religious beliefs are now more prepared to give expression to these, and those without any commitment are more likely to accept that the patient's belief is an area for serious consideration.
7. A big topic that merits another paper: Theology gives pre-eminence in the whole of creation to relationship. God created a Universe of relationships; individuals with God and with each other. This being so, the work of psychiatry is closely aligned with the will of God.

References

- Bhugra D (1996) *Psychiatry and Religion: context, consensus and controversies*. London: Routledge.
- Carey G (1997) 'Towards wholeness: transcending the barriers between religion and psychiatry'. *British Journal of Psychiatry* 170 296-297.

Davies G (2001) *Genius, Grief and Grace: a doctor looks at suffering and success*. Geanies House: Christian Focus Publications.

Fenwick P (2003) cite this Newsletter

Freud S (1937-9) 'Moses and Monotheism, An Outline of Psycho-Analysis and Other Works'. Volume XXIII in *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, ed. Strachey J. London: Hogarth Press.

HRH The Prince of Wales (1991) 150th Anniversary Lecture. *British Journal of Psychiatry* 159, 763-768.

Jones K (1991) 'Law and mental health: sticks or carrots?' in Berrios GE & Freeman H, *150 Years of British Psychiatry 1841-1991*. London: Gaskell.

King M, Speck P, Thomas A' (2001) 'The Royal Free Interview for Spiritual and Religious Beliefs: development and validation of a self-report version'. *Psychological Medicine* 31 1015-1023.

Mayer-Gross W, Slater E, Roth M (1954, 1960 & 1969) *Clinical Psychiatry*. 1st, 2nd and 3rd Editions. London: Baillière, Tindall & Cassell.

McCullough ME, Hoyt WT, Larson DB, Koenig HG & Thoresen C (2000) 'Religious involvement and mortality: a meta-analytic review'. *Health Psychology* 19, 211-222

Shorter E (1997) *A History of Psychiatry*. New York: John Wiley.

Sims A (2003) *Symptoms in the Mind*. 3rd Edition. Edinburgh: Saunders

Sims A (1994) 'Psyche' - Spirit as well as mind?' *British Journal of Psychiatry* 165 441- 446.

Webster C (1991) 'Psychiatry and the early National Health Service: the role of the Mental Health Standing Advisory Committee' in Berrios GE & Freeman H, *150 Years of British Psychiatry 1841-1991*. London: Gaskell.

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