Religious interpretations of mental distress – empirical findings and clinical implications

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Summary

Anthropology has taught us to distinguish between disease and the subjective experience of illness. Mental suffering can become so distressing that the afflicted person experiences it as foreign and externally oppressed. Depending on a person's cultural and religious background the causes can be seen in spiritual forces. Such causal attributions are frequent in delusional disorders, however, they are also found in anxiety and mood disorders, as well as in personality disorders accompanied by behavior and drives which are not acceptable to the individual. Thus, the discrepancy between a person's ideal and subjective experience is interpreted as demonic. Religious interpretations of causality can be understood in the framework of cultural sensitivity, which is underlined in new formulations of the DSM-IV. In an empirical study of 343 predominantly protestant patients, who described themselves as religious, demonic explanations were found in 37.6 percent. 30.3 percent sought help through ritual "prayers of deliverance" (with more or less exorcistic content). Functions of demonic attributions as well as the various forms of deliverance rituals are described. Often patients do not hold rigid convictions of the spiritual causes of their illness. Rather they are developing very subjective interpretations which exist side by side with other medically oriented explanatory models. Although many patients reported beneficial effects as a result of deliverance rituals, psychiatric examination could not observe extraordinary or lasting changes in the symptomatology. Discrepancies in the causal attributions can lead to tensions between therapist and patient. Assessment of religious attributions and their functions should lead to a "shared construction of meaning" resulting in better support and coping.

There is a natural reluctance in patients *and* doctors to discuss deep religious convictions (Spence, 1992). This pertains especially to views on causality that could be rejected by the psychiatrist as superstitious. Nonetheless, the need for an explanation seems to be overwhelming in times of illness and distress (Eisenberg, 1981).

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Patients, in their existential struggle with suffering, tend to draw from deeply hidden wells that have been nourished throughout their lives. Archaic dread, deep somatic sensations, untold interpersonal reactions and long buried religious anxieties and hopes are shaping the answers to the eternal quest for the ultimate causes of suffering.

Religious patients tend to ask more specifically the question of *spiritual* significance of their experience. The painting 'Nightmare' by the Swiss painter Heinrich Füssli (1741 – 1825) gives an impression of the intensity of such feelings. The nightmare, for the sleeping lady in this picture, is not just a psychological process, rather it is a personal attack. She is not just experiencing a pressure on the heart, rather there is a demon sitting on her chest. It is not only the feeling of being threatened and abandoned, rather there is someone in the corner, watching the sleeper's anguish with hideous delight. Thus the psychological phenomenon of sleep disturbance and anxious dreams turns into a drama in which evil forces are directly responsible for the suffering of the person. We should not be surprised to hear such interpretation which go way beyond the predominant model of bio-psycho-social medicine. How can we understand such spiritual attributions? Are there ways to use them in a therapeutic way?

Definitions and examples

Sprituality: An attitude directed towards the intangibly transcendental (God). For the spiritual person this is the source and the goal of his or her life, fundamentally influencing his or her way of living, responsibility and ethics.

Spiritualization: Incidents and experiences are interpreted in a religious context. The interpretation relates to causality and change (therapy) of problems. Subjective experience is perceived in a comprehensive spiritual context. Some examples may clarify the term 'spiritualization':

1) A 22-year old man with a history of psychosis has to be hospitalized with a new episode of schizophrenia. He is hearing voices, is restless and sleepless. To protect himself, he carves crosses in the wall. During the day he feels protected by Jesus and the angels, during the night he feels tormented by demons.

2) A 34-year old mother of three children with a history of an unstable personality is developing a reactive depression. She writes: "I lost all my energy, and my soul filled up with worry. Satan was able to drive a wedge between me and my family. My fears became overwhelming and I even felt the impulse to hurt my youngest child." She asked me: "This is not myself. Tell me, can this be caused by demons?"

3) A deeply religious lady, now 75, has several psychosocial stressors (changing her apartment, loss of eye-sight, hip operation) and developed a depressive episode. "I must have done something wrong, not believing enough.

And now God is punishing me! – I know this, because he does not hear me anymore. I am doomed."

These examples show the broad variation of religious interpretation of mental problems. Sometimes religious descriptions are sounding dramatic; in most cases however they describe the problems in a different language, the language of faith. The main reason is the desire to find a reason for suffering, in order to understand and to better cope with it. This is what the term 'causal attribution' is describing.

Causal attributions and coping

Causal attributions serve to construct a model of explanations to reduce the tension between painful reality and personal hopes, wishes and ideals. Mental problems are especially difficult to understand as explanations are often incomplete, and control is difficult to attain despite efforts to think or act differently. An excellent overview on attributions theory and religious experience has been published by Spilka & McIntosh (1995).

Explanatory models are an important element of every psychotherapeutic process. Jerome Frank (1971) has underlined the fact that one of the common features of every psychotherapeutic school is the presentation of an explanation or a myth which enlightens the causes of a patient's suffering and opens up ways of coping. In order to be effective, such a 'therapeutic myth' has to be compatible with the cultural background which is shared by patient and therapist. The history of psychotherapy is therefore the history of varying explanatory systems with the goal of understanding and healing mental suffering.

Depending on where a person sees the causes ('locus of control') of suffering or an accident, they will react quite differently. A missionary told me the story of a fire in an African village, destroying two huts. A girl had spilled some oil near the fire thus causing the disaster. But the village people did not see it as an accident. They were looking for signs of hidden guilt: "What sin did they commit; which ancestors did they fail to honor, that they were punished so severely?" The consequence: Instead of compassion and support the victims suffered rejection and social isolation. But let us come back to spiritual causal attribution: What is the effect of searching for sin and occult bondage in Christian counseling?

Religious causal attributions

Angermeyer & Klusmann (1988) examined the causes of functional psychoses as seen by patients and their relatives. Among other causal models they also tried to elicit responses on possible 'esoteric' causes (such as environmental

pollution, unfavorable horoscope or possession by evil spirits). In the open oral interview, just about 1 percent of the 198 patients in the study mentioned such a belief. However, in a structured self-report questionnaire 54.9 percent indicated the belief in esoteric items as the 'possible' cause of their disease, and still 22.3 percent as the 'likely / very likely' cause. 3.1 percent thought that 'possession by evil spirits' was a likely or very likely cause of their condition, and 10.9 a 'possible' cause.

Belief in the causation of mental illnesses through evil spirits can be observed in many cultures and religions of the world (Leff, 1988). Such beliefs are brought forward by a variety of patients: There are schizophrenic patients with or without religious convictions, who feel influenced or even possessed by evil powers (Littlewood & Lipsedge, 1981). There are patients with physical or mental illness who tend towards magical thinking, believe in witchcraft and entertain an esoteric world view (McGuire, 1988). However, in most instances, such causal attributions are made by religious patients, as their world view explicitly contains the existence of spiritual powers. On the other hand, they live in a modern world where scientific models are maintaining biological and psychological causes for such phenomena.

How do religious patients then explain their problems in modern Western culture? Which model would they apply in the existential experience of mental suffering? If lay models still prevail in the general population, would there also be specific religious models of causal attribution in religious patients? A further question pertains to the treatment consequences of causal attributions. Would they undergo religious rituals to counteract the influence of evil forces?

An empirical study

We pursued this question in a study which was conducted at the Psychiatric Clinic Sonnenhalde, a mental health center involved in the regional health care system of the Basel metropolitan area and surrounding rural districts. The sample consisted of 343 patients, 114 men and 229 women with an age range of 16 to 70 (mean age = 34.8, SD = 11.4) who were seen over a period of ten years as outpatients by the author. Many of them had been referred by clergy who had attended workshops on 'Psychiatry and Christian Counseling'. All patients described in this study defined themselves as religious, which was reflected in several ways: a) Patients stated that religion was an important factor in their lives. b) They mentioned that regular prayer, bible reading and church attendance were important to them. c) They declared their desire to consult a psychiatrist who showed an understanding attitude towards their faith. Further details of the sample have been described elsewhere (Pfeifer, 1994).

The topic of the demonic was explored in the course of semi-structured interviews at intake or in the course of therapy. Some patients spontaneously asked what I thought on the possible causation of their problems through the

influence of demonic powers. Some reported rituals and prayers aimed at their deliverance from such 'demonic oppression'. Either they had been asking for such a ritual themselves, or somebody in their social network (relatives, friends, clergy) had suggested they should undergo such a ritual prayer in order to find relief. Demographic data and diagnoses were obtained from the patients at intake and were gathered from their records. Care was taken to assess church affiliation in terms of the church patients attended regularly (not official membership in one of the state churches). Four church affiliations were distinguished: RCC = Roman Catholic Church, SRC = Swiss Reformed Church, TFC = Traditional Free Churches, CFC = Charismatic Free Churches.

Diagnoses were the primary diagnoses, made according to the DSM-III-R (American Psychiatric Association, 1987) and then divided into five categories: 1. Psychotic and schizophrenic conditions (PSY), 2. Mood disorders (MD), 3. Anxiety and related disorders (ANX), 4. Personality disorders (PD) and 5. Adjustment disorders (AD).

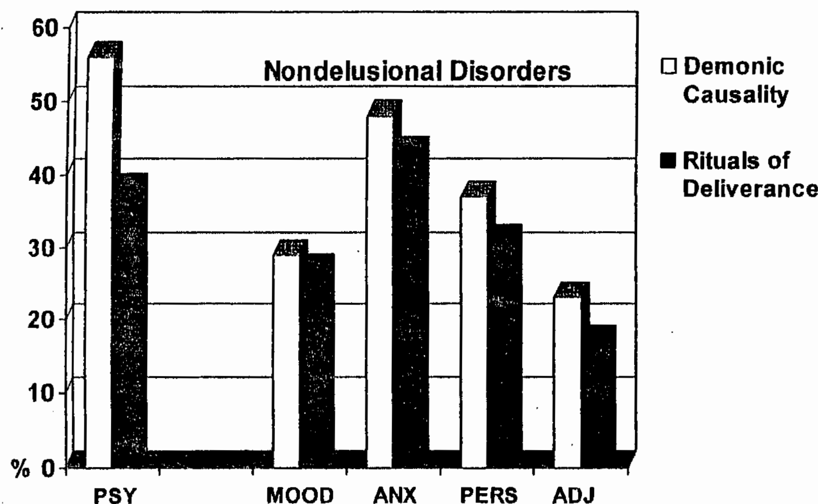

Figure 1: Frequency of belief in demonic causality (white columns) and rituals of deliverance (dark columns) in relation to diagnostic categories (abbreviations are explained in the text).

129 of the 343 patients (37,6 %) believed in the possible demonic causation of their problems. 104 patients (30,3 % of the whole sample) looked for help through prayers for deliverance (figure 1). Two factors were significantly associated with such beliefs: diagnostic category and religious affiliation (the highest frequency of 52 % being found, not surprisingly, in members of CFCs).

However, patients concepts of demonic influence did not correspond with strict criteria of 'possession'. Often they seem to be rather diffuse efforts to

explain psychological distress of anxiety, depression and psychosomatic complaints within the framework of their religious convictions. The most surprising result of our study was the fact that demonic causal attributions were not only frequent in schizophrenia but also in all categories of non-delusional disorders (Pfeifer, 1999). The more intense the impression of ego-dystonic influence, the more frequent was the suspicion of an 'occult' influence.

Although many patients subjectively experienced the rituals as positive (Bull, 1999), outcome in psychiatric symptomatology was not improved which corresponds with research on outcome in other non-medical treatments (Finkler, 1988).

Spiritualization and depression

Spiritual interpretations are by far not always inspired by demonic causation. A 45 year old woman wrote to me during a depressive episode: "When I am in a depressed mood, I have the impression to be abandoned by God. I do not feel his presence and can therefore not believe that he loves me. Faith is nothing but an endless effort, nothing but a joyless walk in the desert. And yet I am longing for him to heal me and to change my situation. When I am out of the depressed condition, I can hear his voice; I know that promises are real and that they are for me ..." For this depressed patient, her suffering is not only described by the items of the Hamilton Depression Scale, nor does she experience it as a biochemical imbalance. Rather her emotional gloom is experienced as the loss of the light of faith which is so central for her; her social regression is overshadowed by the absence of God who in her good times has been guiding and supporting her. These spiritual experiences weigh far heavier than all interpersonal losses and deficits.

Clinical practice shows that even very religious patients do not draw all explanations for their illness from their spiritual background. Rather one finds a multi-faceted *mosaic of causal attributions* of an illness (Pfister & Thiel, 1999). Here are the most common elements of this mosaic: a) the bio-psycho-social model predominant in modern medicine; b) conflicts from their personal experiences; c) cultural traditions; d) alternative body-theories and diets; e) religious convictions; f) spiritual and magical beliefs. Social problems, psychological and somatic symptoms are interpreted with esoteric explanations in varying degrees, but are often not shared with the physician. Often the medical remedies are supplemented with Bach flower remedies or crystals, psychotherapy is perhaps supplemented with Reiki techniques.

Forms and functions of 'spiritulization'

Religious patients will show explanatory and therapeutic models which are in

tune with their (sub-cultural) style of faith. I should like to differentiate four forms of 'spiritualization':

1. *Spiritual forms of inner communication*: "I am speaking with God; God speaks to me." (in prayer, in general thinking, not delusional)

2. *Spiritual interpretation of natural desires and mal-adjusted behavior*; e.g. sexual temptation or temper tantrums are seen as manifestations of specific demons (especially in charismatic churches; Csordas, 1994).

3. *Spiritual interpretation of suffering* without delusional content; e.g. 'affliction', 'punishment', 'chastening', 'temptation'.

4. *Religious delusions* in schizophrenia, sometimes with bizarre content; e.g. on Good Friday a 25-year old woman inflicts a deep cut to her arm, explaining "I have to give my blood like Jesus."

Spiritual explanations serve three functions:

1. *Interpretations* of suffering (causal attribution): e.g. sleep disorders are interpreted as ('demonic') affliction.

2. *Defense mechanisms* against anxiety and change: e.g. a patient insists on regular prayer meetings on her behalf but refuses to face her dysfunctional behavior; e.g. a young man justifies his unrealistic stalking of a woman with the statement: "God has shown me that she will be my wife!" (although she is courting another man).

3. *Coping*: Spiritual support can be very therapeutic. Thus a prophetic word can strengthen a person in his or her struggle with difficult circumstances. A 63 year old farmer described to me how he is dealing with suicidal impulses: "I order the devil to leave me alone. Jesus is victor! Then I start to sing a hymn of victory. I can feel the peace of the Lord coming back to my soul." In his case this unusual procedure serves a positive function of suicide prevention.

These forms of spiritual interpretations show a continuum of intensity. In many cases, empathy is quite possible, for example the failure to attain a religious ideal (e.g."I am not praying enough!"; e.g. "I feel abandoned by God" or in a different vein: „I am damaging my Karma!"). Other religious interpretations however are extremely shaped by subcultural assumptions, when specific demons are made responsible for unacceptable drives and behaviors or for sleep disorders, nightmares or obsessional thoughts.

Forms of spiritual therapy approaces

Spiritual attributions call for spiritual solutions. What are common therapeutic approaches to perceived religious causes? There are many forms of religious healing in all cultures and religions of this world. The following examples are confined to the Christian subculture of the Western world.

Traditional and common are prayer, confession, communion / the Eucharist,

blessings through the laying of hands. More specific are *transitional objects* and protection against evil: *pictures of the saints*, amulets and charms, jewelry with religious symbols etc. *Religious activities* with therapeutic aspects include pilgrimages, participation in religious festivals, religious exercises, visiting special healers. Another category are *various forms of counseling*: 'imagery', prophecy, deliverance ministries, 'rebuking evil forces' (self or others), and exorcism.

The technique of prophetic 'imagery' in charismatic counseling can be very therapeutic. A 34-year old man with multiple anxieties and depressive episodes recounts: "My counselor had an image: I was standing in the midst of a heap of broken rusty chains. The chains were still there, but they were broken. That gave me hope!" – However, such techniques are not without the risk of side effects: emotionally unstable patients can experience deep emotional troubles and crises as a consequence of uncritical prophecies and imagery. A closer analysis frequently shows a mixture of spiritual support with popular superstition (especially in catholic and orthodox context) or with psychoanalytic Pop-psychology (e.g. in the charismatic literature).

Dealing with sprititualization

An important guideline for dealing with spiritual interpretations is an open attitude: "*Approaching the unfamiliar with respect helps us to gain understanding.*" Therapists should be open to accept patients even if they present with unusual pathways to care (Peteet, 1981; Schiller & Levin, 1988). A therapist has to take into account his or her own counter-transference in order to prevent a rejecting attitude on the basis of his or her own experiences with religion (Greenberg & Witztum, 1991). We have to keep a balance between openness for subjective models of a patient and careful evaluation of a person's psychosocial situation. This is achieved in three steps: a) assessment; b) evaluation and c) the development of a useful procedure.

1. *Assessment* will focus on the following aspects: Is the spiritual the explanatory model for suffering or is it just a secondary phenomenon? Are we dealing with delusion or with a religious subculture shared by the patient's family or church (Lukoff et al., 1992; Greenberg, 1984)? What are the psychodynamics or the spiritual interpretation: does it serve coping in a positive way or is it rather a dysfunctional mechanism of defense (Meissner, 1991; Narramore, 1994; Lovinger, 1979)? Ultimately assessment will focus on the therapeutic consequences resulting from the religious interpretation of the problem. Can spiritual elements serve as one aspect of a therapeutic strategy?

2. The *evaluation* of spiritual interpretations should be done in close cooperation with the client/patient, in an empathic effort to understand his or her

personal 'illness narrative' (Kleinman, 1988). Even religious therapists will not always find this to be easy, as different forms of 'religious style' can cause tensions of interpretation. Often it is not possible to simply take over the spiritual model of the patient, as the therapist has the right, even the moral obligation, to know his or her spiritual position and to hold on to it without verbally expressing it in all its facets. The theological discussion – "What is truth?" – as important as this question is, cannot be the primary focus of therapy. Rather we have to ask: "What is the influence of the spiritual model on general coping ability and psychosocial development of a person?" In the evaluation of spiritual resources it is important to distinguish between functional and dysfunctional forms of religiosity (Spilka, 1989). The crucial question is: What is the influence of religious interpretations on symptom relief, coping with life events and psychosocial development of the patient/client? Ideally, spiritual interventions should lead to a marked symptom reduction, combined with personal freedom, improved interpersonal relationships and enhanced coping abilities (figure 2).

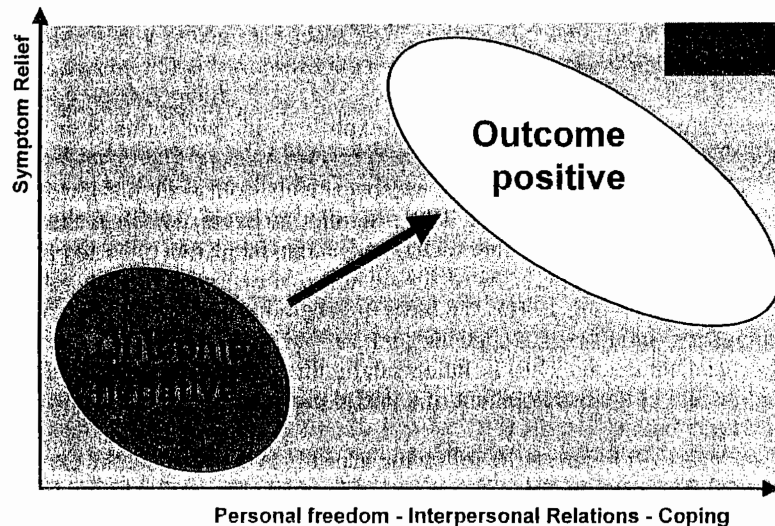

Figure 2: The Spectrum of outcomes of non-traditional healing.

Assessment and evaluation will eventually lead to a formulation of *therapeutic strategies* including spiritual elements. Here are some guidelines: a) Develop a supportive therapeutic setting in collaboration with the patient; b) Spirituality is seen as part of a comprehensive model of illness and coping; c) Cooperation with counselor/pastor (if possible). An important strategy is psycho-education to make patients aware that religious life can be affected by mental illness (e.g. depression). I am often using the image of a piano which is out of tune. No

matter how well you follow the notes and how brilliantly you press the keys, it will sound wrong. Thus all spiritual efforts will not always result in joyful mood or energetic functioning. Weakness is part of our human condition. Depression can freeze feelings and narrow the thinking process, leading to the impression that God is silent and his word is not speaking to a person's heart; that guilt becomes so overwhelming that even intensive repentance cannot bring that inner peace of mind. However a patient can be assured that religious life will come back after the depression has receded (even without specific religious efforts). A discussion of the interaction of body, mind and spirit of neurotransmitters and the emotional life can bring further clarity. This '*reframing*' describes the spiritual as part of the image but not as the sole indicator or the only underlying cause. Often it is helpful to discuss with a patient which aspects of his or her spiritual life and interpretation are functional and which are a burden in the present situation. Not always will it be possible to find common ground, as some convictions are deeply ingrained and strongly held. Theological arguments are rarely helpful. In some instances the only strategy is to 'agree to disagree'. This can be the case when a patient repeatedly and against her therapist's advice is seeking help in destructive exorcism or at an obscure healer although emotional conflicts are foreseeable. However the therapist should offer his availability in case of failure or the recurrence of a new episode of the underlying illness.

In religious terms, the goal of an understanding therapist should be the development of mature spirituality characterized by the following criteria: it improves self-confidence (based on confidence in God); it enables mature patterns of interpersonal relating; it enhances coping with life's demands and daily stressors, and it preserves the awareness and the awe of the ultimate spiritual reality, God.

Conclusion

The construction of meaning on the background of sub-cultural values is a universal phenomenon (Kleinman et al., 1978). In their help-seeking behavior (Rogler & Cortes, 1993), many religious patients would consult the doctor as well as a Christian counselor or healer, combining medication with prayer. Often physicians, healers, and counselors are unwitting partners in health care (Murray & Rubel, 1992). It is therefore important to understand the function of such causal attributions, even if they seem incompatible with medical and psychological models at first. The practices and beliefs described in this article are religious forms of alternative healing rituals existing within the multifaceted aspects of Western culture (Eisenberg et al., 1993).

Cultural sensitivity includes the ability of the therapist to understand religious

aspects of illness interpretation and to utilize functional aspects of religion in a patient's coping process. This not only helps to strengthen the therapeutic relationship but can also lead to enhanced compliance and ultimately better therapeutic outcome in religious patients.

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