British Journal of Psychiatry (1995), **166**, 284–286

Editorial

Religious Experience Within Mental Illness
Opening the Door on Research

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While conventional religious practice shows signs of decline, this does not necessarily imply a decline in religious belief. It comes as a surprise that psychiatrists should be so reticent in their inquiry into this aspect of their patients' emotional and cognitive experience. Only 3% of a qualitative review of the total output of four major psychiatric journals between 1978–1982 contained a quantified religious variable, and only three out of 3777 articles scanned were centrally and quantitatively concerned with traditional religious phenomena (Larson *et al*, 1986). This deficiency has attracted protest (Sims, 1994). According to a review conducted by the author, the *British Journal of Psychiatry* published no papers that had religious belief as a principal focus of psychometric concern between 1988–1992.

Building upon Professor Sims' protest by defining the research agenda is intended here. Barriers to and potential benefits of psychometrically based research are discussed and some relevant areas for research of clinical importance are proposed.

Barriers to research

Evidently there is a risk that psychiatrists tend to construe religious belief in psychopathological terms. There has been a plea recently to protect religious belief from the iatrogenic tendencies of current diagnostic coding and provide 'psychoreligious' and 'psychospiritual' experiences as conceptual safe havens via a 'Z' code in the new DSM–IV (Lukoff *et al*, 1992).

Collectively, American therapists tend not to share their clients' religious outlook, although many acknowledge a spiritual dimension to their lives (Bergin & Jensen, 1990). Ignorance among psychiatrists concerning behavioural and attitudinal aspects of religious belief is a recognised educational issue within the Royal College of Psychiatrists. Furthermore, theoretical opposition to metaphysical beliefs has been both influential and orthodox in the development of psychoanalytic and in some cognitive therapies. The risks of a prejudicial analysis of religious phenomena – for example by failing to distinguish psychopathological forms from their religious content – are therefore potentially high.

There are potential ethical problems. A survey of 193 psychiatrists holding evangelical Christian beliefs demonstrated that one-third would discourage strongly non-religious patients from behaviour that violated Christian belief (abortion, homosexual acts, premarital sex) (Galanter *et al*, 1991). As in the assessment of psychosexual problems the act of inquiry into religious belief may not be a morally neutral event – it can convey attitudes of approval or condemnation. Although patients may welcome their clinician's inquiry into their spiritual state, giving spiritual guidance may be an illegitimate act of trespass onto the territory of the ordained minister. In 1990 the American Psychiatric Association was concerned enough to issue guidelines to clinicians who may seek to modify their patients' beliefs (APA, 1990). Patients may be peculiarly vulnerable to influence by their clinicians' attitudes on account of their mental state and the internal structure of the therapeutic relationship.

There is also an issue of feasibility. Even at a philosophical level definition of religious experience remains a highly contentious issue. Phenomenologically religious experience is no less complex. The measurement of religious practice or affiliation may be easy but quantifying existential commitment is not. Furthermore, sex, age and socioeconomic status are important confounding variables; other specific difficulties in getting access to belief include cultural barriers, deficiencies in verbal skills and defensive attitudes.

Conceptual frameworks

Within the academic field of religious psychology a number of approaches familiar to psychiatrists have been borrowed from the contemporary psychological tool box to capture the concept of religiousness. For example, the explanatory function of religious belief lends itself to analysis by Attributional theory. Religious propositions can have a distinctive attributional style – helping people achieve meaning, esteem and a sense of control – that, among other factors, may be shaped by mental illness. God concepts can reflect inner dispositions; they can speak

of the self. Accordingly images of God may vary with self-regarding attitudes – positive self-esteem correlates with loving, accepting images and negatively with rejecting controlling images (Spilka *et al*, 1985). A minority of psychiatric in-patients are also known to make religious attributions to explain their illness, and some early studies concerning God images and self-concepts in the mentally ill confirm a reflexive pattern.

Other theoretical models have also been used to gain access to subjective religious experience. Using Personal Construct theory, Preston & Viney (1986) found that positive affect and low levels of guilt relate to construing God as loving, nurturing and caring. Attachment theory has been proposed as a useful framework to understand links between content of religious belief and patterns of adult relationship (Kirkpatrick & Shaver, 1992).

Religious experience is often articulated in the language of relationship – the self and God – and as such has the qualities of being dynamic, provisional and responsive, but potentially vulnerable to being challenged if not changed by mental illness.

For some people the proximity of the religious experience makes it difficult to talk about, but this also provides the theoretical opportunity to gain intimate access to areas of potential clinical importance, for example in the assessment of mood, hope and self-esteem. Reproducible methods of observation are obviously crucial.

Measurement

Psychometric measurement of religious belief is a neglected area within psychiatry, but has been developed over 40 years in other behavioural sciences. Numerous scales examining many aspects of belief and practice of variable psychometric quality are available but remain substantially unused in mental illness populations. The majority of scales have been derived from North American Christian populations. One of the dominant concepts has been the notion of intrinsic and extrinsic orientation measured on the Religious Orientation Scale (Allport & Ross, 1967). Intrinsic belief is a valid measure of religious commitment that may also have other cognitive correlates (Spilka *et al*, 1985), whereas the extrinsic orientation demonstrates a pattern of use rather than commitment and has been correlated with, for example, prejudicial attitudes (Allport & Ross, 1967). Trait anxiety has been reported to be negatively correlated with the intrinsic pattern of religious commitment, and low levels of depressive ideation and high self-esteem have been reported to correlate positively with intrinsic orientation in the elderly (Nelson, 1990). There are at least 70 published studies using the Religious Orientation Scale and although its conceptual framework is not beyond question it at least attests the feasibility of a psychometric analysis of religious belief.

Potential research topics

Research of religious experience within mental illness is at a formative stage but an initial focus may be to build upon some of the correlations noted to exist in the psychologically healthy. Three examples can be given.

Firstly, people who show a high level of existential commitment to their belief system are likely in the course of a mood disorder to experience a spiritual crisis.

Take for example, the sonnet of desolation (number 65) of the Jesuit, Gerard Manley Hopkins (1844–1889):

> "No worst, there is none. Pitched past pitch of grief,
> More pangs will, schooled at forepangs, wilder wring.
> Comforter, where, where is your comforting?
> Mary, mother of us, where is your relief?"

The descriptive task would be to map out this crisis in relationship to the behavioural, physical and cognitive aspects of a mood episode. The simplest hypothesis to be tested would be that severity of depression matched severity of spiritual desolation. Observation of the latter could be focused on repeated and structured examination of the relational language of religious belief: conventionally and biblically God has many images and is experienced subjectively at variable distances particularly within the context of regular prayer. Attempts have been made to make factor analyses of these God images and could provide a starting point for structured inquiry.

Building upon descriptive tasks are analytical ones. Although there is evidence to suggest moral constraints play a role in inhibiting self-destructive behaviour, and hopelessness is acknowledged to play a role in facilitating it, the provision or withdrawal of religious hope and suicidal risk has not been systematically evaluated. What weight should be given to religious apostasy in the assessment of risk, or come to that, conversion experience? A hypothesis to be tested could be that people with an intrinsic pattern of commitment who, in the course of illness, lose belief would generally score more highly on indices of hopelessness as strength of commitment wanes.

Lastly, very little is known about religion as a form of coping behaviour with psychiatrically disabled patients. Koenig *et al* (1992) suggest that religious coping is a common and important mechanism in adapting to physical illness in elderly men – particularly with severe functional disability where a sense of control is lost. Religious coping was inversely associated with depressed states in this group, but good descriptive data is lacking in the chronically mentally ill. Should such inquiry prove to be acceptable to patients an intervention study could elucidate the clinical profitability of explicitly identifying and subsequently reinforcing this form of coping behaviour. The simplest intervention could amount to a routine and repeated inquiry about religious cognitions and practice.

Discussion of religious issues within the psychiatric assessment interview is often ignored but also avoided, possibly because it can provoke a sense of mutual discomfort and a sense of trespass – like sexuality it can be a matter of unspeakable embarrassment because it is simultaneously intimate and relational. Psychiatric research into religious phenomena generally colludes with this unspoken policy of avoidance but may be impoverished as a result. This is particularly disappointing as the conceptual and psychometric apparatus for inquiry may be available and adaptable for use and could turn a tradition of protest about the absence of research into clinically rewarding data.

Acknowledgements

This article could not have been written without the helpful comments of the Reverend Professor Leslie Francis and the secretarial assistance of Jane Jones.

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(First received 28 March 1994, final revision 8 August 1994, accepted 12 September 1994)