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Psychiatry and Religion: World Psychiatric Association Beyond Boundaries

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Objective. This paper will reflect on the significance of the discussions on 'Religion and Science' for the World Psychiatric Association (WPA). Reflection on this topic has not even started yet despite the publication of a WPA handbook on 'Religion and Psychiatry: Beyond Boundaries', started up by the WPA Section of Religion, Spirituality and Psychiatry.

Discourse. Following the model proposed by the Dutch philosopher of Religion and Ethics Willem Drees, two statements will be formulated and discussed:

4. The WPA, indeed representing world psychiatry, needs to change its position toward religion and spirituality. It should do so by crossing narrow minded scientific boundaries like reductionist and materialistic boundaries.
5. Psychiatry and religion should not be regarded as opposing adversaries against each other, but as allies against superstition and nonsense.

Conclusion. The boundary between religion (and spirituality) and the practice of psychiatry is becoming increasingly porous. No longer can psychiatrists in a multi-faith, multi-cultural, globalized world hide behind the dismissal of religious belief as pathological, or behind biomedical scientism. Consequently, there is a far more important reason for engaging in 'Religion and Science' than the outdated conflicts. That reason would be the persistence of (religious and scientific) superstition and nonsense.

Key words: Science, Religion, Psychiatry, Cosmology, Axiology, Apologetics

Psiquiatría y religión: La Asociación Mundial de Psiquiatría más allá de los límites

Objetivo. Este artículo reflejará la relevancia de las discusiones sobre "Religión y ciencia" para la Asociación Mun-

dial de Psiquiatría (AMP). La reflexión sobre este tema aún no ha comenzado, a pesar de la publicación por parte de la AMP del manual 'Religion and Psychiatry: Beyond Boundaries', emprendido por la sección de religión, espiritualidad y psiquiatría de la AMP.

Discurso. Siguiendo el modelo propuesto por el filósofo de religión y ética holandés Willem Drees, se enunciarán y discutirán dos afirmaciones:

9. La AMP, representando la psiquiatría mundial, necesita cambiar su posición en relación a la religión y la espiritualidad. Se debe hacer yendo más allá de las constricciones científicas de mente estrecha como las reduccionistas o materialistas.
10. La psiquiatría y la religión no deben considerarse adversarias, oponiéndose una a la otra, sino aliadas contra la superstición y el sinsentido.

Conclusión. La frontera entre religión (y espiritualidad) y la práctica de la Psiquiatría cada vez es más porosa. Los psiquiatras no pueden esconderse mucho más tiempo detrás del rechazo a las creencias religiosas como patológicas o detrás del cientificismo biomédico en un mundo globalizado de múltiples fes y culturas. En consecuencia, hay una razón importante para enlazar 'religión y ciencia' más allá de los viejos conflictos. Esta razón podría ser la persistencia de supersticiones y sinsentidos (religiosas y científicas).

Palabras clave: Ciencia, Religión, Psiquiatría, Cosmología, Axiología, Apologética

INTRODUCTION: CENTRAL THEMES LISTED

There is a lot to tell and to explain with regard to the interface between psychiatry and religious experience. Despite recent publications and reviews of empirical findings it is still well-timed to discuss the central themes in more length and in more depth. A long list of these 'central themes' could be enumerated. To give a specimen of such an overview: in a World Psychiatric Association (WPA) volume

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on Religion and Psychiatry the editors distinguished seven fields of interest.¹ First of all, in response to a question like 'Where to begin?', they started with so-called Prolegomena: history, philosophy, science and culture. This opening intends to draw the readers' attention and stimulate reflection on core historical and philosophical considerations when contemplating religion and mental health. It seems as if psychiatry still has to start (over again) with the historical and philosophical problems at the interface between psychiatry and religion.

Secondly, since about 80 percent of the world population embrace one of the known religious traditions and circa 4,200 different religious/spiritual groups are known, psychiatrists inevitably need to know about core issues of various world religions given the social and cultural context of their clinical practice. The necessary information on religious traditions circles around a central figure (or figures), a central message and central structural elements. From there it is illuminating to look at ideas, concepts, popular beliefs and religious practices regarding health and mental illness.

Psychopathology is the core business of psychiatry. So, thirdly, a lot needs to be explained about religious psychopathology. In the volume cited not only religious experience and psychopathology, normal and abnormal religiosity, psychosis and depression and obsessive compulsive disorder are discussed, but also religion from a psychoanalytic perspective and religious fundamentalism. On the one hand, conceptual elimination of religious and spiritual aspects may ultimately lead to psychiatrists losing their patients. On the other hand, religious and spiritual issues and their dynamics are interwoven with the process of symptom formation.

To these three main issues several others could be added. The neuroscientific developments have broken down the dualistic barrier between observation and behavior and the activation of brain structures. There is no mental function that is not orchestrated by processes activated in the brain. And still mind matters. The challenge is to explain why, and to do so not in opposition to neuroscience. In the meantime research and empirical studies are necessary in order to clarify the possible relations between religion and mental health; religion can be harmful, religion can be helpful and a generally positive force. Still a lot has to be achieved. In evaluating empirical data one always needs to keep in mind that researchers' choice of this or that indicator of religiosity and measure of a (specific form of) psychological disturbance is guided by more or less explicit ideas about what religion and mental health are. This list is not complete without mentioning the interdisciplinary and training issues. Multidisciplinary teams are commonplace in mental health institutions. Psychotherapy, pastoral care and spiritual care and meaning giving contribute to the care of psychiatric

patients. Their discipline-specific assessments have a lot to add to our understanding of the patient concerning diagnosis and treatment interventions. Psychiatric residency training, continuous medical education and psychotherapy training lay the foundation of acquirement and improvement of knowledge, skills and attitude. The very same holds true for religion, spirituality, worldview and the interface between psychiatry.

'DEADLY DANCE'?

Although it is not really difficult to image that these 'central themes', as I called them, have (or perhaps used to have) something to do with each other, it is not clear at first glance how and even why they interconnect. It is here that we enter the intriguing field of thinking and discussion of science (psychiatry) and religion. Science and religion have often been seen as enemies locked in mortal combat; an unnecessary and in fact unacceptable stance. The start of psychiatry is in fact an illustration of this development in which religion lost its leading position and the physician became the new guide in life with scientific and moral authority. Since then the relationship between psychiatry and religion has been strained to a greater or lesser extent.

We are used to Barbour's fourfold typology as the standard manner to present the relationship between science and religion. He proposed a description of the field of 'science and religion' using four categories: conflict, independence, dialogue and integration. However, one could elaborate on this scheme and argue that on the social level of science (psychiatry) and religion these four types of relations correspond to four types of attitudes health care professionals may take towards their own religious involvement and toward their religiously or spiritually involved patients.² The Swedish professor of philosophy Stenmark formulated a threefold typology: a) no overlap between science and religion (independence view), b) overlap between science and religion (contact view), c) union of the domains of science and religion.³ Barbour's dialogue and integration are two versions of the second type according to Stenmark. In his model he emphasizes that it is important to pay attention to the aspects where science and religion might be related. He takes into account four dimensions: the social structure of science and religion, the aims of these practices, the kind of epistemology they exhibit and the theoretical content. This approach helps us to get a more differentiated picture of the interactions between science and religion. What would be for instance the overlap, if there is any, and the difference between psychiatry and religion in a teleological sense? If it would be appropriate to say that both practices aim at 'healing' or at helping relationships, there would still be a great difference between mental health and welfare (salvation) as a goal and in healing methods despite the fact that the relationship

between 'the healer' and 'the healed' is fundamental for employing the method in both practices.¹

TWO STATEMENTS

The 'locked position' is clearly not fruitful and should be changed for several reasons. Obviously, the boundary between religion and spirituality and the practice of psychiatry is becoming increasingly porous and this asks from psychiatrists to be more knowledgeable. Another important development is that, although spirituality is not mentioned as an aspect of the definition of health, the World Health Organization (WHO) has rightly regarded religious, spiritual and personal beliefs as a component of quality of life. Thirdly, the growing awareness after nearly a century of neglect may necessarily enhance the study of religion and spirituality in psychiatric training, research and practice. Organizations like the WPA should take the lead. Therefore, I would like to formulate two statements:

The WPA, indeed representing world psychiatry, needs to change its position toward religion and spirituality. It should do so by crossing narrow-minded scientific boundaries like reductionist and materialistic boundaries.

Psychiatry and religion should not be regarded as opposing adversaries against each other, but as allies against superstition and nonsense.

FIRST STATEMENT

I ask WPA for another position, a new position with regard to religion and spirituality. Another position asks for another vision! We need a new, a better view on 'science and religion'. No doubt WPA has a vision on science and psychiatry. However, it could be argued that this vision on science is a one sided view on human nature, the world and on religion. One-sided because it is dominated by gathering evidence, mathematical modeling, systematic empirical testing, with the goal to provide the fullest and most reliable explanations for everything that occurs in the natural world.⁴ One sided, in more meta-theoretical terms, because of its really understandable ideal of a detached, external position in order to achieve objective knowledge. (Clearly religious understanding cannot be achieved from such a position.)

In the meantime science does play a role in the way we live and the way we perform our professional duties, whether religiously or non-religiously. Religion does play a role in the way we look at, make use of and live with science. And both religion and science are about the truth of ideas, and about the acceptance of religion in a science-minded culture and about the acceptance of science in a religiously minded context.

Before proceeding I need to explain that for the sake of the argument I will take an outsider perspective on religion. In other words, I will not argue from a religious point of view. The insider perspective would be based on particular creeds, revelations or experiences. If I were to do that I would immediately cause a lot of trouble, because it would seem as if I had chosen in favor of a certain religious tradition and against other traditions. I would immediately lose my case, because WPA would never, and justly so, take such a position; that would be disastrous! In fact, the danger of such a partiality has crippled WPA (and WHO) in developing a view on religion and health. My position in this paper is the one of the outsider and observer. I am arguing not about the truth of religion, but about the best available truth about religions. Religion and science, as a theme, speaks of that which we value, that which we hold to be true, and that which we hold to be possible. And as an outsider perspective on religion, human nature and the world it is a vision that reflects upon its own possible meaningfulness, truth and value.⁵

What kind of vision do we need? I will follow the analysis and the model developed by the Dutch philosopher of religion and ethics, professor Willem Drees in his *Religion and Science in Context. A Guide to the Debates*.⁵ Looking at religious views it is reasonable to say that religions can be defined as systems of symbols, and that symbols bring together, so to say, people's ethos and their world view.⁶ Symbols bring together the appreciation of reality and the norms for our behavior. So it would be reasonable to argue that a world view, religious but also non-religious I would say, has a descriptive and a prescriptive aspect. For instance, to speak of the world as God's creation has a descriptive and a prescriptive aspect to it. Take for example the Christian doctrine of humanity being made in God's image. Humans are thus seen as created, with a special position as the height of God's creation. This leads to the idea of human stewardship of creation in contrast with an idea like human ownership of the world. A world view, religious and non-religious, offers a view of 'the way the world is and should be, of the true and the good, of the real and the ideal'.⁵ In other words, the vision we need offers a particular cosmology - as a view of the way reality is - and an axiology - a view of the values that should be realized - . The same example: to speak of the world as God's creation is a cosmological claim, and that we therefore need to be good stewards is a normative claim.

So what we have now is a religious or non-religious vision that in a certain way holds together two dimensions. It is important to draw attention to two parts of this way of phrasing. It is essential to notice the aspect of 'holding together'. In 'religion and science' it is of course important to analyze the cosmological aspects; that is the contribution science makes to our worldview. However, it is also necessary to be aware of where other judgments come into play; judgments not based on science but on moral, aesthetic or

religious preferences. Otherwise we would move from factual to normative claims without recognizing. In the second place, it is exactly this 'in a certain way' that offers a lot of openings for further exploration and reflection, especially in such a diverse multi-religious, multicultural organization like WPA. For instance, we speak of religious or non-religious visions, by which we do not imply that this or that non-theist's non-religious view is deficient in understanding, nor that a theist's view is deficient, but that they hold different existential positions in the way they hold together these two dimensions. The same holds true for different theistic or non-theistic religious positions. Another opening would be this more specific one. The certain way in which the cosmological and axiological dimensions are held together allows for prioritizing. We are allowed to concentrate on existential issues which become prominent when our reality is not in accord with what we think ought to be.^{5, 7} This is really a typical experience of psychiatric patients confronted with the burden of mental illness! And still it is hard to recognize the existential dimension in patients' stories. It appears to be much easier to pay attention to the facts than to the 'whys' and 'wherefores'. The question is, however, whether that really is proper prioritization, although we do not want to minimize whatsoever is known about the diagnosis and treatment of that illness. On the other hand, it would also be thinkable that the patient makes a cosmological claim with regard to the origin of his illness, for instance possession by a demon. The professional cannot ignore this by just pathologizing such a claim.

I followed the line of reasoning by Drees and I will summarize our findings. We called WPA for a new position toward religion and psychiatry. We started looking for an appropriate view on 'religion and science'. And what we have found is a religious or non-religious view from which we distinguished but designedly not separated two aspects: the cosmology and the axiology. Cosmology is related to science, is related to underlying experiments and observations, is related to world and daily life. Axiology is related to ethics, is related to underlying moral intuitions, is related to world and daily life.⁵ Drees presented an oval figure: at the top 'a (non) religious vision', at the bottom 'world & life', at the left hand side the line along 'cosmology' as designated, at the right hand side the line along 'axiology'. I would like to challenge WPA to start working on a vision like the one presented; in my view it is a far more promising model compared to what has been done, or actually has not been done, with regard to psychiatry and religion.

SECOND STATEMENT

Assumedly, we are more or less acquainted with Barbour's view on 'religion and science', as I mentioned before. As I indicated, Barbour describes the field of 'science and religion' with the help of four categories, or rather four

relationships: conflict, independence, dialogue and integration. In general one might expect, given what is said about the (lack of) religious or spiritual commitment among mental health professionals, that the adherents of the first and/or second category will outnumber the other two (or three). What to think of this anecdote? In 2006 two Dutch psychiatric residents and their residency training director reported on a small qualitative research of 13 psychiatrists currently working in a mental health service. The psychiatrists were each interviewed about their attitude towards religious belief and spirituality. The interviewers were particularly interested in the possible role religion played in the relationship between psychiatrists and their patients. Reporting on countertransference issues, the Dutch interviewers quoted a typical statement from one of the psychiatrists' interviews, 'If one learns that a patient is a believer, that patient's estimated IQ will actually be rated 20 IQ points lower'. About half of the 13 psychiatrists interviewed attributed similar negative qualities to the religious patient.⁸

Barbour's first relationship might be in a sense the most problematic one because of the forced choice it seems to provoke. Therefore the second one might conceal in a sense what is going on. Anyhow, the second one and the other two give more or less the impression to mitigate the tension that is inevitably implied in the first one, as Drees noticed.⁵ In fact those who happen to be religiously or spiritually involved probably opt for a more friendly separation and division of labor (second relationship), a modified science (third relationship) or a more far-reaching integration (fourth relationship). Drees calls this the 'ecumenical gathering' in 'religion and science'.

For a community like WPA there is a great risk in this. Such an 'ecumenical' gathering could be in danger of excluding opponents of religion just as they would exclude opponents of modern science. Drees⁵ argues that an element of apologetics is involved here. Apologetics means justifying a particular belief or practice to others. In the 'religion and science' debate we see two fronts. On the one hand, religion is defended in a secular scientific environment. On the other hand, science is defended among those who are worried about threatening scientific insights like evolution.⁵ In our handbook we tried to escape from such an apologetic stance.¹ In fact we just did what Drees is pointing at. In the foreword a mild 'independence' relationship seems to be observed in the field of psychiatry, and is cautiously called into question. In the preface the underlying tone is direct: 'That psychiatry in the twentieth century was largely a "Godless" period was not to the advantage of the psychiatric patient'. Religiosity can be considered a *normal* personality trait and cannot be disregarded by psychiatrists, whatever their own ideas on religiosity might be.¹ However, as soon as one starts to discuss such core constructs as disease, mental health, religiousness and spirituality all kinds of background

issues, assumptions and convictions, mindsets come about. We are quite sure that psychiatry is not helped forward by any form of religious apologetics or expansionism; the model sketched in the first part of this contribution should help us to be aware of the many pitfalls.

Another risk is that an 'ecumenical' gathering as depicted places us in a defensive position. The strategy would be something like making a stand against the secularizing impact of science. Although we want to make a positive case for more effective relationships between psychiatry, religion and spirituality,⁹ the risk is an agenda to counteract the advance of that science that seems to make religion mistaken or irrelevant. In the meantime, we do not seem to be very successful, in fact nothing seems to stop the advance of science, in any case not religion.

The innovative and intriguing position Drees takes is taken up in my second statement. There is another thinkable reason for engaging in the 'religion and science'. Our concern does not need to be 'the future of religion but the persistence of superstition and nonsense'.⁵ If that would be our joint concern the agenda and partnership in religion and science, in religion and psychiatry would be completely different. Challenging superstition and nonsense would be very satisfactory not only intellectually and religiously, but also socially and morally. Psychiatrists are all familiar with cases in which the patient is told by his spiritual healer that positive thinking in a spiritual or religious way will be healing. Let that pass. In fact there is enough empirical evidence supporting the idea that religiosity might have a supportive and/or protective effect.¹⁰ That many psychiatrists around the world are not aware of these facts is less appealing. But when the patient does not become well he might unnecessarily receive the burden of failing spiritually. Challenging superstition and addressing the nonsense in our field cannot be successful from the defensive position I pictured.

It calls for a new dialogue, an interreligious and inter-spiritual dialogue, even a new kind of spirituality.¹¹ If we develop our view along this line of thinking we need to attempt as good as we can to differentiate between genuine spirituality and superstition, between science and pseudoscience. In other words, we need quality in our reflections on religion and science.⁵ In my view that will be the most important challenge to WPA. Searching for quality criteria, Drees formulates ten criteria paraphrasing the ten commandments.⁵ Paraphrasing the second commandment he writes: In religion and science we should not make carved images, in other words, we should not adore simple solutions. That is to say: 'Avoiding ambiguity or indeterminacy might be helpful and clear things up, but resolving ambiguities by throwing out nuances and meanings is not helpful at all in exploring reality'.⁵

There are no universally accepted criteria for quality nor with regard to genuine spirituality (psychiatry tries to

manage with only two criteria: level of functioning, and cultural congruence¹²), nor with regard to science.¹³ That would be our next challenge: working on quality in our reflections on religion and psychiatry.

CONCLUSION

I would like to conclude with an fine example by John Cottingham, that illustrates the holding together of a cosmological claim and an axiological one. According to Cottingham⁴ we could argue that a scientific hypothesis may reasonably be adopted if it provides the most comprehensive and plausible account available of a given range of observable data. It is taken for granted that science has the capacity to explain. That has not always been the case. According to another position science was confined to description and prediction. However, there is no normative model of explanation in terms of one set of essential conditions for explanation, we have to work with 'a plurality of models'.¹³ On the other hand, religious claims about the world or the cosmos are no explanatory hypotheses like scientific explanations. Religious claims need to be consistent narratives (consistency is one of the criteria for assessing religious or non-religious views of life),¹⁴ like this: 1) God's creation is necessarily imperfect, since logically it needs to be less perfect than God himself. Otherwise it would be like God instead of being created. 2) God's creation, given his infinitely outgoing nature and creativity, will include a material universe, the material cosmos we are living in. 3) Matter by its nature, as a series of unimaginable fleeting energy-interchanges, involves constant entropic decay. 4) We human beings are formed out of matter. Reflection on 3) and 4) shows that creatures formed out of the dust of earth will necessarily be mortal, which also means that the human condition is inherently vulnerable, and always subject to (the possibility of) suffering. The conclusion based on a narrative like this is that vulnerability, mortality and suffering are not just compatible with standard theistic principles regarding a perfect creator, but in fact derivable from those principles.⁴

As I said, a religiously committed narrative like this holds together both an exposition and interpretation by faith or religious conviction and explanation by science. Cottingham certainly helps us in adding quality to our reflections on science and religion.

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