THE SPIRITUAL LIFE OF PEOPLE WITH MENTAL HEALTH PROBLEMS

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IN THE LAST TWO DECADES THERE HAVE BEEN AN AMAZING SERIES OF DEVELOPMENTS AFFECTING THE RELATIONSHIP BETWEEN MENTAL HEALTH PRACTITIONERS AND THE RELIGIONS. From a position which understood all religions to be forms of delusion, and therefore the religious views of people with mental health difficulties to be at best irrelevant or at worst profoundly mistaken and unhelpful, there has developed an increasing respect for what is often called their "spirituality". This has largely come about through self-advocacy and the users' movement, rather than through theological critique. At all events it is now hugely to be welcomed that the religions are not marginalised by mental health professionals, and there exists a Health Service Guideline (HS9(92)2) exhorting "where necessary … every effort to provide for the spiritual needs of patients and staff".

The problem is, of course, what is meant by "spiritual needs"? The last decade has also seen a growth in mental and other health literature on "spirituality". The definition of "spirituality" which has commended itself, for very obvious reasons, embraces both the classic world religions and various non-theistic philosophies of life. The search for or discovery of meaning in life through self-transcendence, with or without belief in God or any form of participation in religious practices, becomes the hallmark of "spirituality" so defined, such a definition fits comfortably, as others have observed, with contemporary styles of Western secularisation. But the question which needs to be faced is whether such a massive departure from the classic meaning of "spirituality", a term which developed within a Christian context to refer to the content of the spiritual life, is justified and helpful.

It is an understandable mistake to assume that the matter is in any way settled by a definition. Definitions have their uses, and are indeed essential in legal contexts. But there are many words in current use, "art", "democracy", "religion" and so forth where the complexities are such that definitions do not resolve them. In such cases, if a definition is imposed on the material, it will simply be a shorthand for the theory which the person imposing the definition holds – a theory which is bound to be controversial and therefore no solution at all.

With reference to "spirituality" whether there is such a thing as an existential life-meaning, shared by people with and without religious faith, could not be an uncontroversial matter, still less a presumption. To apply it to the term "spirituality" as a definition would be the conclusion of a long theoretical discussion – a form of shorthand for a particular writer's theory. All too often in the literature it is simply quoted from other sources, and taken for granted.

We have been here before. An historian of theology will recall the way in which the concept of "religion" was used in nineteenth- and early twentieth-century theology. Christianity and all other world faiths were subsumed in the subject "religion", which was defined as the overarching category of which Christianity was a specific example. It took some very fierce criticism of "religion" so understood as "criminal arrogance against God" from Karl Barth in the early twentieth century to remind us that there was a theological problem at stake whose solution could not be presumed simply by invoking a definition, whether Barth was right or wrong in his contention.

Does the spiritual life of people with mental health difficulties in any way depend on how the term "spiritual" is understood? Mercifully not! Provided, that is, that no unjustified presumptions are made about what that life ought to consist in. Provided, too, that inauthentic religious attitudes are not imposed upon people. How then ought the words "spirituality" or "spiritual-life" function? My suggestion is that they ought to act as a kind of exclamation mark, a reminder to the therapist or other mental health professional to pay attention, not to look away or make assumptions, when the religion of a person experiencing mental health difficulties comes up.

A reminder to pay attention should be a reminder to pay *close* attention. When a person's case history is taken the role which religion of some kind or other plays in his or her life should not be passed over as of no importance; a medical practitioner ought to be expected to be capable of real sophistication in the interpretation of the way in which a person participates in the corporate memory of the modern religions, including of course mutations of, and alternatives to, the principal religions of the Western world. In this field a competent medical practitioner is in need of a good contemporary model, such as that provided by Grace Davie in her sociology of religion, for understanding the contemporary forms of religious life.[1]

It is a substantial and rather daunting requirement, difficult enough for a chaplain in a mental health unit, exceptionally demanding for a psychiatrist, to have some kind of empathy for the role which religion may place in the life of a patient. But it certainly deserves

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serious consideration. A religious person, virtually by definition, lives his or her life in the light of God. In Christian faith there is an assumption of God's fundamental goodness of will, and love for his creatures. To experience mental illness may involve serious questioning concerning God's intentions, his providence and his relationship with his creation. Many but by no means all Christians in this situation are acutely affected by profound feelings of guilt, sometimes made worse by a sense that they ought to be able to surmount their problems by an exercise of faith. It is no easy matter to help someone to a balanced sense of being loved and valued by God, as an integral part of the process of healing.

The particularity of the beliefs of a person with a mental health problem is what deserves attention. This, of course, raises the problem of what a therapist may consider to be inappropriate beliefs, such as, for example when a patient is convinced that what is required is a ritual of religious exorcism.

The subject of exorcism is a large one. It also plays a thoroughly unhelpful role in the modern media, assisted by popular knowledge of such films as *The Exorcist*. In a recent work which examined the role of Jewish and Christian faith communities in relation to people with mental health difficulties it was acknowledged that some Christians hold that a deliverance ministry is helpful. An English broadsheet greeted this with the headline, "Government-backed report says: exorcise your way to mental health" (*Sunday Telegraph*, 3 October 1999), together with a photograph from *The Exorcist*. The fact is, however, that exorcisms are somewhat less likely to be carried out in Catholic than in conservative Protestant contexts, and are related to a particular way of understanding the Gospels.

How then is Jesus' exorcistic activity to be understood? The question arises for anyone reading the Gospels in the twenty-first century. The answer for anyone for whom the New Testament is a sacred text could be that there is no difference between those in the narratives described as possessed by evil spirits, and those currently described as mentally ill. The answer to the same question sponsored by the thinkers of the European Enlightenment could be that the first-century description was the pre-scientific attempt of ignorant people, now replaced by more rational and objective explanations.

Medical anthropology has developed a third possibility. A distinction is drawn between disease, a concept with a more organic reference, and illness, having to do with social impact of the specific phenomena. Jesus' compassionate response to the distress he encountered was mainly to do with the latter, his message of hope for all, his call to action, his offering forgiveness, and his practice of inclusiveness. The stigmatisation and isolation of distressed people is still a feature of the way in which we construct their "illness" in society, despite enormous strides in the treatment of organic conditions.

Inclusion has a boundary, of course; there are delusions which lead to harm to others or to oneself. The experience of some forms of serious depression are truly frightening. Many forms of schizophrenia impose great suffering. In all such cases, medical intervention is the appropriate response of someone who cares for the person involved. But the medicalisation of every mental health problem has its own boundary. There are instances where unusual experiences have positive – or at least no negative consequences. One is gloomily conscious of the number of saints and mystics whom an over-zealous health service would have sectioned – even straitjacketed. We would do well with a larger tolerance of difference and a less constraining interpretation of the normal. ■

NOTES

1. See G Davie, *Religion in Modern Europe: A Memory Mutates* (Oxford: Oxford University Press, 2000).