Mental Health and the Church

A Report for the Archbishops' Commission on Families and Households

Mental health services and the Christian Church have much in common; they are concerned with the wellbeing and flourishing of people in their social and cultural context. By virtue of the European Enlightenment, we have come to see them as more different than they really are, with the former addressing people's physical and psychological wellbeing – according to the biopsychosocial model that is now almost universal in medicine – and the latter confining itself to spiritual wellbeing. However, human beings cannot readily be disassembled in this way. Spiritual wellbeing is too closely interconnected with psychological wellbeing, and it is virtually impossible to measure spiritual wellbeing without invoking psychological concepts, such as peace, relationship, meaning making, and purpose in life. Indeed, according to the canonical Gospels, Jesus addressed the physical, social, and psychological wellbeing of those to whom he ministered in first century Palestine and did not confine himself to a separate category of "the spiritual".

In this report I will reflect briefly upon the way in which Church history and biblical scholarship demonstrate this mutuality of concerns between the Christian Church (in a very broad sense, but with the Church of England particularly in mind) and mental health services.

Church History

The earliest Christian hospitals for the mentally ill may be dated back to 4th century Byzantium. By the 5th century the shrine of St Dymphna, in Gheel, in modern day Belgium, had become a popular destination for pilgrims seeking healing from mental disorders and a tradition of caring for the mentally ill continued in the surrounding area up until the present day. In 1247 the Hospital of St Mary of Bethlehem was founded, becoming known in the 16th century as "Bedlam", and in 1930 merged with the Maudsley Hospital in south London to become a major centre of research and clinical care.

Much is often made of the attribution of mental illness to demon possession in the Middle Ages, but distinctions were made between spiritual (including demonic) affliction and what we would now call mental illness. The extent to which mental afflictions were labelled, sympathetically or otherwise, as spiritual or moral problems probably had more to do with social tensions than with Christian theology or psychopathology. Individuals might be accused of witchcraft or divine punishment by their enemies, but illness by friends and family.

The evolution of attitudes towards the mentally ill has a complex history. The development of a more liberal and humane approach to treatment has by no means been the preserve of the Church, but in Christian Europe individual Christians played a significant part. Juan Luis Vives (1493-1540) played an important early role in promoting a more humane approach to the mentally ill, with Philippe Pinel (1745-1826), Vincenza Chiarugi (1759-1820) and William Tuke (1732-1822) later playing a significant role in the promotion of the so-called "moral approach" in France, Italy and England, respectively. Of these, Tuke was notably motivated by his faith as a Quaker, and the hospital that he founded, The Retreat, at York, remains to this day.

In the late 19th century mental disorders increasingly came under scientific scrutiny and this led to deterministic understandings of two kinds. A biological view of mental illness as brain disease was

pioneered by, amongst others, Wilhelm Griesinger (1817-1868). The role of unconscious processes was emphasised by Pierre Janet (1859-1947). These dual strands of thought and research, both of which were in their own way unsympathetic to a Christian approach, continued to influence thinking through the 20th century, but it is perhaps Sigmund Freud (1856-1939) who did most to create antipathy between Christian and secular understandings of mental disorder. Notably, this was expressed in his work, *The Future of an Illusion* (1927), to which the Swiss Lutheran minister, lay psychoanalyst, and close friend of the Freud family, Oskar Pfister responded with counterarguments in *The Illusion of a Future* (1928). Freud, unlike his pupil Carl Jung (1875-1961), saw religion as evidence of neurosis, rather than as human flourishing. However, the rise of behaviourism, finding human behaviour to be psychologically determined in ways fundamentally similar to those observed in the animal kingdom, whilst fundamentally diverging from Freud's theories of psychoanalysis, also played its part in widening the rift between Christianity and the scientific and clinical world of mental health care.

A turning point in this tide of history, by the mid-twentieth century so unfavourable to the Christian worldview, was marked by the publication of a 1967 paper by two Harvard psychologists, Gordon Allport and Michael Ross. Allport and Ross showed that religiosity could take different forms, and they distinguished particularly between intrinsic religiosity (inwardly motivated) and extrinsic religiosity (social motivated). Extrinsic religiosity was found to be associated with significantly greater prejudice (e.g., towards those with mental illness, racial prejudice, and antisemitism) than intrinsic religiosity. Intrinsic, but not extrinsic, religiosity has subsequently been shown to be associated with better – not worse – mental health in numerous empirical research studies. Thousands of subsequent research studies have shown that, in fact, religious affiliation is usually associated with better, not worse, mental health.

In the later part of the 20th century a further turning point was navigated by the emergence of popular notions of spirituality as somehow different from religion. Whilst spirituality is difficult to define, being notoriously confounded with psychological variables in research studies, it has also become very important to many patients, including both those who identify as "spiritual but not religious" (SBNR) and those whose sense of spirituality is intimately interconnected with their religious beliefs. A key driver towards a rapprochement between the worlds of spirituality/religion and mental health service provision has thus come from "service users", patients who identify spirituality as an important part of their wellbeing and a key to understanding their illness in context. This has been evidenced in various research publications, notably in the UK the 2000-2001 Somerset Spirituality Project. Spirituality/religion have thus come to be seen as an important coping resource, to be encouraged and not undermined, by mental health professionals.

These trends have expressed themselves in professional debate, and particularly in developments led by Christian, and other religious/spiritually motivated, psychiatrists. In 1956 the American Psychiatric Association established a Committee on Relations between Psychiatry and Religion. In 1993, Andrew Sims – a Christian psychiatrist and President of the Royal College of Psychiatrists (RCPsych) - addressed a conference of the RCPsych in the UK, exhorting colleagues not to neglect the spiritual concerns of their patients. In 1996 the Archbishop of Canterbury (George Carey) was invited to address the annual conference of the RCPsych. In 1999 a Spirituality and Psychiatry Special Interest Group was established within the RCPsych to enable psychiatrists to discuss together the ways in which spirituality impacts upon their work.

If psychiatry has gradually moved itself towards a somewhat more sympathetic relationship with the Christian Church, then there is also evidence that the Church has reciprocated. In 2003 the General Synod of the Church of England debated mental health issues. A further debate was held in 2008,

with representatives from the RCPsych invited to be in attendance. In 2019 the Archbishop of Canterbury hosted a conference on mental health at Lambeth Palace. It is less clear, however, what the tangible and enduring outcomes of these initiatives have been, or that the Church of England knows exactly how to address mental health effectively amidst an era in which mental illnesses are predominantly cared for within the health service, and in which medical technology and research have made care both expensive and complex.

The Bible

Narratives about, and commentary on, mental health are not difficult to find in the Judeo-Christian scriptures. The Psalms of the Hebrew Bible (the Christian "Old Testament") are full of affective language – addressing all the human emotions, from anger to love, and sadness to joy. In particular, the so-called Psalms of lament express the very depths of human feeling amidst adversity. The book of Job, written sometime between the 7th and the 4th centuries BCE, addresses the experience of suffering – mental and physical – made worse by friends who are sure that the protagonist is actually experiencing divine punishment for wrongdoing, even though he has done nothing wrong (and is eventually justified by God). The traumatic experiences of the exiled Hebrew people following the military devastation of Jerusalem in the 6th century BCE are addressed at various points in the Hebrew scriptures, not least within the book of Jeremiah. Moving on to the New Testament, we find Jesus addresses significant themes of worry and anxiety in his sermon on the mount in Matthew's gospel, and an apparent encounter with a man suffering from a major mental disorder (the so-called Gerasene demoniac) in Gospels according to Matthew, Mark and Luke. All of the canonical Gospels show Jesus addressing themes of stigma and exclusion, wherein he always identifies with and cares for those whom others consider unclean or unworthy. Despite this, it would seem that neither Sunday School classes for children, nor sermons for adults, when addressing biblical themes, give anything other than rare or passing attention to mental health issues in most churches.

If mental health themes may readily be found in the Bible, then we might also observe that the Bible is not too difficult to find within the world of mental health. In a direct sense, this has been historically evident in the content of psychopathology, whereby those who suffer delusions and hallucinations, for example as a part of a major mental disorder, manifest biblical content. Their delusional thought takes on biblical themes, and their hallucinations may be of God speaking to them. However, there are other ways in which the Bible may be found in the world of mental health. The internal divisions of the self, evident in addictive disorders, seem very similar to the experiences that Paul discusses in his letter to the Romans. Many visionary and voice hearing experiences affirmed in scripture, amongst both prophets and patriarchs, look similar to the phenomenology of some mental disorders. This has been used by critics to dismiss the validity of Christian revelation, but perhaps it also brings into scrutiny an undue readiness to dismiss the experiences of some patients as meaningless, when they may in fact be spiritually meaningful?

It is not the case, then, that the Bible and mental health are worlds apart – they address common human concerns, albeit separated by time and culture so that the language of each is often unfamiliar to the other. Notwithstanding some important exceptions (e.g., religiously integrated CBT, or forgiveness therapy), we need to get much better and finding connections and translating these different ways of thinking so that there may be better mutual understanding in the pew and in the clinic.

An Agenda for Action

Returning to the question of the mutual concerns of Church and mental health services, as posed at the beginning of this paper, how may we bring about better understanding of each for the other in support of a shared vision of human flourishing and a more collaborative approach to realising it? I would suggest that this is not just a question of setting up a mental health working group (although I do currently chair such a group, under the auspices of one Church of England committee) but rather of finding ways to get mental health into every area of church life and practice. This is not a contrivance on my part, but rather the need for an opening of eyes to the presence of mental health concerns in almost everything that the Church does.

Ordination training has a notoriously stretched curriculum including such diverse matters as systematic theology, church history, biblical studies, ethics, pastoral theology, liturgy, and more. Within this, mental health typically occupies very little space and rarely ventures beyond the pastoral theology class. Newly ordained priests and deacons are therefore ill equipped to deal with the enormous mental health burden carried in most parishes around the UK and further abroad. What if – without too much further pressure on the existing curriculum – biblical studies routinely included attention to examples relevant to contemporary mental health challenges: the mental trauma of exiled Jerusalem, or the major mental disorder of the Gerasene demoniac? How often do examples taken up in ethics classes address the dilemmas presented by false guilt (in obsessional compulsive disorder, or depression) or lack of conscience (in antisocial personality disorder)? How about an assignment to design a liturgy for the depressed and anxious members of a congregation? As we have already seen, there is also scope for teaching church history in a way that leads us to a better understanding of the present rift between Church and mental health services.

Perhaps most importantly, we need to ask why clergy do not address mental health themes in their preaching (lack of training – or fear, perhaps?) and consider how training may better equip them to preach (literally) on the things that are really worrying members of their congregation. Similarly, Sunday schools and youth groups probably do not tackle these issues as often as they should (although it is difficult to find hard data on this). In training on children and youth work, attention needs to be given to innovative ways of communicating about these themes with young people. I well remember meeting with a church youth group, many years ago, in which a young person had died by suicide. We should have taught them about deliberate self-harm and suicide before this tragic event – not afterwards.

As a priest and psychiatrist with an academic background, it is perhaps predictable that I would say we need more research, and better evidenced based writing (papers and books), on mental health and Christian faith. I think we do need these things – but we also need to get better at communicating what we do know using social media, the world wide web, and other more engaging approaches to informing, motivating and supporting the next generation in tackling these issues better than we have done in the past.

Finally, I would propose, we need to do all that we can to bridge the gulf between the worlds of Church and mental health by more collaborative working between chaplains, clergy, and mental health professionals. It is remarkably difficult to get mental health chaplains, let alone parish clergy, closely involved in the technical and confidentially boundaried world of modern medicine. It is almost as difficult to get mental health professionals working in the context of faith communities (although – again – there are some happy exceptions and some excellent resources to facilitate this).

The world of mental health has amazing resources to offer to clergy, chaplains and ordinary Christians in support of mental flourishing; the Church has some even more amazing resources to offer to help patients in mental health services cope better and flourish spiritually. We need to find new and more imaginative ways to bring these worlds together.

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