IS FAITH DELUSION?

By Professor Andrew Sims

It has been claimed that God is a delusion. I plan to examine that proposition from the standpoint of psychopathology. Delusion has now become a psychiatric word. Although in the past, the word delusion could refer to being fooled or cheated (Oxford English Dictionary), in modern speech it always implies a suspicion of psychiatric illness. It has been appropriated by psychiatry and invariably implies a psychiatric diagnosis. If I am deluded, then I am necessarily mentally ill. In English law, delusion has been the cardinal feature of insanity for the last 200 years (West & Walk,1977). It is a mitigating circumstance and can convey diminished responsibility. It is, therefore, within our professional competence as psychiatrists to say what is, and is not, delusion.

I have had the temerity to entitle this, 'Is faith delusion?' as if I could answer that question for all faiths and, therefore, know about all religions and philosophies. Of course, this is not so, but there is a dilemma here; the person who can state, objectively, 'religion is, or says...', in doing so, puts himself outside religion, and all religion, each faith, can only be truly known from inside. I therefore hope that the disadvantage of not being able to speak for all religions is outweighed by knowing well the subjective experience of one type of believer.

Are all people with religious belief, a priori, suffering from mental illness? Sigmund Freud in 'Moses and Monotheism' stated that belief in a single God is delusional (Freud, 1937-9). His contemporary, William James, was somewhat more circumspect and considered that spiritual and psychotic experiences were broadly distinguishable (James, 1902/1997). In this paper, I intend to answer the question of my title from the standpoint of descriptive pathology. I will then discuss what other psychiatric symptoms or syndromes could be used to explain the presence of religious belief. If faith is not evidence of an Axis I psychiatric disorder (DSM-IV), is it a feature of personality disorder or abnormality? Finally, I want to discuss what religious belief is phenomenologically.

THE PSYCHOPATHOLOGY OF DELUSION

In order to answer the question of my title, I am going to review, briefly, the descriptive psychopathology of delusion and then consider how faith, or religious belief, fits in with this phenomenology. How do psychiatrists determine if something is delusional, or not? The study of individual personal experience is fundamental to psychiatry. Descriptive psychopathology is the precise description and categorization of abnormal experiences as recounted by the patient and observed in his behaviour (Sims, 2003). There are two components to this: careful and informed observation of the patient, and phenomenology, which implies, according to Karl Jaspers (1959) the study of subjective experience. The descriptive psychopathologist is trying to hear what the patient is saying without any theoretical, literary or artistic gloss of interpretation, and without the mechanistic explanations of science used inappropriately.

In order to achieve understanding, phenomenology uses empathy as a precise clinical tool. In Jaspers' usage, understanding is contrasted with explanation. Understanding, in this sense, involves the use of empathy, subjective evaluation of experience by the 'understander' using his or her own qualities of observation as a human being: feeling inside. Explanation is the normal work of natural science involving the observation of phenomena from outside, and objective assessment. Both are required of the practicing doctor but whereas the method of observation in science is carefully and comprehensively taught, teaching the method of empathy to give subjective understanding is frequently neglected (Sims,1992). Delusion is, in Jaspers' (1959) expression, ultimately "ununderstandable", that is even putting oneself in that person's position and seeing the world from their point of view, one is still unable to understand how they could hold that belief with delusional intensity.

PSYCHOPATHOLOGY; THE DISTINCTION BETWEEN FORM AND CONTENT

The patient is only concerned with the content of an experience: 'the nurses are stealing my money', whilst the doctor needs to be concerned with both form and content: 'is my patient's belief that people are stealing from her factual; a misinterpretation; delusion; or some other form?' Content reflects the predominant concerns of the patient, for example, a person whose life has centred on money, and fears of poverty, may believe that she is being robbed. The form indicates the type of abnormality of mental experience, and this leads to diagnosis. Thus it does matter whether this belief of the patient is a delusion, or not.

A man believed that he was 'at war with the Evil One', that everyone he met was either a friend or a foe, and that devils were talking about him, taunting him and commenting upon his thinking. The phenomenological form categorizes subjective experience and reveals the psychiatric diagnosis; in this case the form was both a delusion, and an auditory hallucination in the third person saying his own thoughts out aloud. The latter would be considered to be a 'first rank symptom of schizophrenia' Schneider K (1957). The content is dictated by his cultural context, in his case, religious. He believes in a continuing conflict with a personal force of evil, and that this battle affects the whole of life; of course, this content would be shared by many Christians. So the form reveals the nature of the illness whilst the content arises from the social and cultural background. Only the study of the form can reveal whether a symptom, such as delusion, is present or not, and this can be explored by finding out how the notion is experienced by this individual.

DEFINITION OF DELUSION

A delusion is a false, unshakeable idea or belief, which is out of keeping with the patient's educational, cultural and social background; it is held with extraordinary conviction and subjective certainty Sims, 2003). In practice, definition is the imposition by the doctor of his interpretation of the patient's subjective symptom and is rather unsatisfactory. Delusion is experienced as an ordinary notion or assumption rather than a belief, for example, 'it is my belief that Susie broke the champagne glass', not 'I believe ...' as a credal statement.

A delusion is held on delusional grounds. A man knew, with absolute certainty, that his wife was being unfaithful to him. Subsequently, it transpired that she was being unfaithful at that time. However, this was still a delusion because the reason for his certainty was: 'When I came out of the house and passed the fifth lamp post on the right, it had gone out. Then, I knew, with certainty, that she was unfaithful.' Technically, this would be described as a delusional percept: a

normal perception (the light gone out) with a delusional interpretation (that certainly means that she is unfaithful).

DELUSIONS ARE HELD WITHOUT INSIGHT

If someone wonders if they are deluded or not, they almost certainly are not. A Christian colleague, after a long silence, said, 'I suppose the difference between delusion and faith is that delusion is held without any doubt, but religious belief is held with some doubts, or at least an understanding that others could have doubts.' This is reminiscent of the father of the epileptic boy who was healed by Jesus: 'I do believe; help me overcome my unbelief!' Mark 9: 24. Whereas delusions command rock like certainty to the deluded, believers only require a minute amount of belief – like a grain of mustard seed - as a foundation for their faith Luke 17: 6.

CONCRETE THINKING

Those with religious beliefs accept that some of their expressions are spiritual and not to be acted on literally, for example, 'giving your heart to the Lord Jesus'. In some serious mental illnesses there are abnormal processes of thinking resulting in a literalness of expression and understanding. Abstractions and symbols are interpreted superficially without tact, finesse or any awareness of nuance: the patient is unable to free himself from what the words literally mean, excluding the more abstract ideas that are also conveyed. This abnormality is described as concrete thinking and delusions are concrete. I have known of patients who interpreted literally, that is concretely, the scriptural injunction, 'if your eye ... your hand...offend...cut it off.' (Matthew 5:29). Concreteness is useful in making the psychopathological distinction between the disturbed thinking of the patient with schizophrenia and the description of internal experience of a person with strong religious beliefs (Sims, 2003).

SUMMARIZING DELUSION

Is faith a delusion? Although, not infrequently, the content of delusions is religious, faith, of itself, is not a delusion. This is true even for minority and socially disapproved beliefs. For some cults, abnormal psychological processes may be frequent but these are not delusions for the following reasons:

1. They do not fulfil the criteria for definition of delusion - it is not 'out of keeping with the patient's cultural and social background'.
2. They are not held on demonstrably delusional grounds.
3. Religious beliefs are spiritual, abstract, not concrete – 'God within me' is not experienced as a tactile sensation.
4. Religious beliefs are held with insight - it is understood that others may not share their beliefs.
5. For religious people, bizarre thoughts and actions do not occur in other areas of life, not connected with religion.
6. Religious ideas and predominant thinking is a description of content. Religious delusions occur in a person whose predominant thinking is religious. Faith is part of their personhood; delusion arises from psychiatric disorder. A person with religious belief may have a delusion but only if they have a concurrent psychiatric illness.

CAN OTHER PSYCHIATRIC SYMPTOMS EXPLAIN THE PRESENCE OF RELIGIOUS BELIEF?

If religious faith is not delusional, is it, per se, a manifestation of any other psychiatric symptom or syndrome? The following are contenders for that honour:

1. Shared or communicated delusion
2. Overvalued idea
3. Culturally held shared belief
4. Paranoid idea of reference
5. Abnormal mood state (Anxiety disorder, Affective disorder – depression or elation Depersonalisation)
6. Pathological perception - Hallucination – 'hearing' the voice of God.
7. Disorder of volition – locus of control.

SHARED AND COMMUNICATED DELUSION

This condition is designated in the International Classification induced delusional disorder (The ICD-10 Classification of Mental and Behavioural Disorders (1992). This occurs when a delusion is shared by two or more people; it used to be called folie à deux, à trois etc.

It is not similar to religious belief. In a case report describing folie à quatre, the patient who was initially seen believed that a large industrial concern had put 'bugging' devices in the walls of his brother's house (Sims et al. 1977). He claimed that employees of the firm had been following him everywhere and interfering with his own house. His wife, the protagonist who showed 'communicated delusion', believed this story initially and produced supposedly corroborative evidence.

A year later, following his in-patient treatment, she no longer accepted the plot and believed her husband to be mentally ill. She was a very anxious person. When the patient's brother was visited at home, it was found that he, and the sister who lived with him, both believed in the plot and were both currently receiving treatment for a schizophrenic illness.

OVERVALUED IDEA

This is a solitary, abnormal belief that is neither delusional nor obsessional in nature, but which is preoccupying to the extent of dominating the sufferer's life (McKenna, 1984). It is usually associated with abnormal personality. A highly abnormal religious belief could sometimes be regarded as an overvalued idea. For example, an individual repeatedly desecrated churches because he believed they displayed images of which he disapproved.

CULTURALLY HELD SHARED BELIEF

It was difficult to recruit nurses to work in the psychiatric hospital in Lusaka, Zambia because most trainee nurses shared the belief that you can 'catch' mental illness from the patients. Clearly, beliefs shared by members of a religious minority would also fit into this category. However, DSM IV states that a delusion 'is not an article of religious faith" (DSM-IV:765).

PARANOID IDEA OF SELF-REFERENCE

A doctor from the middle-east belonged to a small, persecuted Christian group. He came, after being tortured at home, as a refugee to Britain. He learnt English and re-qualified. He said that one of his teachers had described himself as 'anti-Christ' and, on another occasion he thought that a Jehovah 's Witness who visited him at home must be involved in a plot against him personally because he spoke Arabic. The Occupational Health Physician wondered if he was fit to practice and asked a psychiatrist to examine him. His ideas were not delusional, but, because of his previous experiences, he interpreted many harmless circumstances as threats directed at him personally.

ABNORMAL MOOD STATE

This might include anxiety disorders, affective disorders – either depression or elation and depersonalisation. Does religious faith cause, for example, anxiety, depression, mania, and so on? This topic would merit further discussion, but, in brief, this is where we might apply the distinction between form and content. A keen member of an active church who met with other church members 3 or 4 times a week became depressed; she had prominent religious notions in her depressive symptomatology.

A young monk who became manic said that God had given him special powers to know what people were really thinking. Religion has not caused depression or mania, but when the mental illness has occurred, the content has been religious in nature. In general, those with religious faith have a better outcome from psychiatric disorder (Koenig et al, 2001). It has been claimed, although not based on epidemiological studies, that there are negative effects of religion on depression when there is emphasis on original sin (Branden, 1994).

PATHOLOGICAL PERCEPTION

This has been excellently covered by Dein (2008). We have to thank Professor Romme for reminding us that hearing voices does not necessarily imply mental illness, and certainly not schizophrenia (Romme et al, 1989). The Old Testament prophets, St Paul and many people today speak of 'hearing the voice of God'. Are all these describing hallucination: perception without an object? (Esquirol, 1817). No, this voice is not experienced as something outside self, neither as a sensation that another person might hear. Quite often it has an 'as if' quality. The subject describes it as spiritual, abstract and not concrete, physical.

DISORDER OF VOLITION – LOSS OF CONTROL

Has the person with religious belief lost his capacity for independent action, believing himself to be completely controlled by God from above, like a puppet on a string? There is evidence that those with religious belief are more likely to experience internal locus of control, and this is associated with better functioning (Jackson et al 1988).

What I have described are unusual mental states, and some of them are pathological. All of them can be associated with religious belief, but that is not the same as claiming that religion, per se, is or causes psychiatric disorder. Faith is not delusional, neither does it cause, of itself, any other psychiatric condition or symptom.

I have reviewed just these seven phenomena: shared or communicated delusion, overvalued idea, culturally held shared belief, paranoid idea of reference, abnormal mood state of anxiety, depression, elation or depersonalisation, pathological perception, and disorder of volition. We have seen how each of these can be associated with religious belief and practice in a person for whom faith is important. We have not found any causal link between religion and psychopathology.

PERSONALITY ABNORMALITY AND DISORDER

If we make the distinction in DSM IV between Clinical Disorders (Axis I) and personality disorder (Axis II), as faith is not a clinical disorder, is it a feature of personality disorder? If religious belief is not a symptom of formal psychiatric disorder, is it evidence of disturbed personality? Some psychiatrists in the past would imply that this was so, for example, Mayer- Gross, Slater, and Roth in the 1960s stated that religion is for 'the hesitant, the guilt-ridden, the excessively timid, those lacking clear convictions with which to face life' (Mayer-Gross et al 1954/ 1960 / 1969).

In fact, the situation is very similar to that applying to mental illness and religion: the manifestation and expression of religious belief, even the religious group to which one has allegiance, is substantially affected by personality structure but the belief itself, or even this individual holding that belief, is not caused by, or a feature of, personality abnormality or disorder.

The beliefs themselves, and that an individual should have religious belief, is not caused by personality factors. However, the manifestation of belief, the subjective experience of faith and the particular regime of practice is very much influenced by the personality. Martinez (2001), a Spanish psychiatrist, has elaborated on this, using Jungian personality typology, for prayer. 'One of the most beautiful things we find in God's creation is variety. The main reason for understanding the way we are, our temperament and personality, is not to make us feel better but to make real improvements in our relationships, both with God and with our brothers and sisters.'

It would be worth devoting a whole conference to personality and its disorders. These six questions could profitably be discussed:

1. Why do some people find spiritual life and the whole of life, so difficult whilst others appear to cruise through, finding everything easy?

2. Is not the distribution of personality, and other innate endowments, unfair?

3. Definitions of personality include such words as persistent, long-standing. How can we have a model for personality that allows for change?

4. If what we do is determined by our constitution, an innate tendency, why do we hold people responsible for antisocial behaviour?

5. How should we classify persistent moral badness – is it a psychiatric condition?

6. Is there an essential discontinuity between those with personality disorder and those with 'normal personality'?

Unfortunately, this intriguing subject has to be abandoned. Individual personality, abnormality of personality and personality disorder are clearly

relevant for spiritual experience but the relationship is complex. It is helpful to be aware of personality characteristics for religious believers and those they come into contact with. It will affect many aspects of their religious belief and practice. It would be a nonsense, however, to stand this important statement on its head and claim that religious belief is 'nothing but' the expression of a disordered personality.

We have considered whether faith is a psychiatric symptom or evidence of disturbed Personality and concluded that it is not. In fact, the epidemiological evidence is that there is an association between religious belief and practice and good or better mental health. The massive Handbook of Religion and Health, by Koenig et al. (2001), surveys 1200 studies and 400

reviews and concludes: 'In the majority of studies, religious involvement is correlated with well-being, happiness and life satisfaction; hope and optimism; purpose and meaning in life; higher self-esteem; better adaptation to bereavement; greater social support and less loneliness; lower rates of depression and faster recovery from depression; lower rates of suicide and fewer positive attitudes towards suicide; less anxiety; less psychosis and fewer psychotic tendencies; lower rates of alcohol and drug use and abuse; less delinquency and criminal activity; greater marital stability and satisfaction.

WHAT IS FAITH PHENOMENOLOGICALLY?

I have here set myself a question I cannot possibly answer! Faith is not psychopathological; there is no evidence of mental illness affecting all believers. What is the nature of the subjective experience? Obviously, it is very different for different people at different times.

I am going to look at this with the tunnel vision of the psychiatrist and the blinkers of the descriptive psychopathologist. I shall not consider at all the rich vein of mystical, artistic and theological writing on the subject. We will, very prosaically, only consider cognitive, affective and volitional aspects. The word belief is, of course, cognitive. The religious cognitions of many believers have often been summarized in creedal statements: 'I believe in God...' This is fine for establishing uniformity, but, in practice, each person will interpret the unadorned words in their own individual way. They will also, without thinking further, associate the solely cognitive side with affective and volitional aspects: 'My belief in God gives me a feeling of belonging'; 'Belief in God affects what I do, it gives me a code of behaviour'.

Each aspect has implications for self experience and relationships. Saying to myself, inside my mind, the phrase 'I believe in God' establishes and defines what I know about myself in terms of the five formal characteristics of self according to Jaspers (1959) and Scharfetter (1981:273-280):

1. The feeling of awareness of being or existing, 'I know that I exist'.

2. The feeling of awareness of activity. 'When I move my arm, I am aware of myself'.

3. An awareness of unity. 'I know that I am one person'.

4. Awareness of identity. There is continuity; 'I have been the same person all the time'.

5. Awareness of the boundaries of self. I can distinguish what is myself from the outside world, and all that is not the self (Sims, 2003).

There is also a bearing on relationships: obviously the relationship with God, but also relationships with all other individuals. Psychiatry teaches us that people, patients, cannot be considered as if living in a vacuum, one must take the social milieu, in its widest sense, into account.

Arising from the limitations of a highly reductionist psychiatry is the tendency to 'boil down' affect into a few very simple descriptions: depression, hyperactivity, anxiety, guilt feelings, and so on. The real world is much more complex, both in range and in the combination of different, sometimes conflicting, emotions. For the religious believer there is a massive and very varied affective element associated with the experience of faith. This does not mean that religious belief 'is just emotion', or that believers cannot exercise their minds and examine the evidence. The affective aspect of faith also has a relational side; belief implies involvement with God and with others.

Religious belief is volitional – an act of will, and willing actions. Cognitive acceptance of creedal premises with the affective assumption of faith leads to individual actions and a code of behaviour consonant with those beliefs. Morality is necessarily linked to activity.

However, as always, volition is not straightforward. The conflict within the self is variously described but universally recognised. St Paul put it: 'I do not understand what I do. For what I want to do I do not do, but what I hate I do.' Romans 7: 15. St Augustine, whilst agreeing with Paul, stressed the nature of the divided will rather than the divided self. Cook (2006) has examined the dilemma of the will for alcohol abuse and addiction, but this is applicable for other areas of relevance for the psychiatrist.

He describes the different models that have been used to explain alcohol abuse: some propose the alcoholic as the victim of his environment or his genes; some have him as the weak-willed agent of his own catastrophe. Cook points out the need for a second order volition: 'to want not to want to drink'. He stresses that the internal conflict is serious, with dire consequences, and that addicts need more than just their own will power. Relief from the lethal habit requires grace, and grace comes from the act of not rejecting it. This, if you like, is a theological model for alcohol abuse, that can be extended more generally to problems of volition, all of which have a moral element, and how to deal with them practically.

CONCLUSION

I started with the question, is faith delusion? I spent some time looking at precisely what delusion is in psychopathology and then measuring religious faith against it. I concluded that faith, of itself, is not and cannot be delusion, although people frequently have delusions that include religious and spiritual content. I covered briefly various other abnormal phenomenological states and found that, although those with religious belief may well experience them, faith was not causative. I also looked at the nature of personality to assess whether faith could be construed as a product of abnormal personality. Although variations of personality affect the manifestation and self-experience of belief, religious faith exists independent of personality. Finally, I examined the phenomenon of faith, observing its cognitive, affective and volitional aspects. This process has been carried out from the perspective of descriptive psychopathology.

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