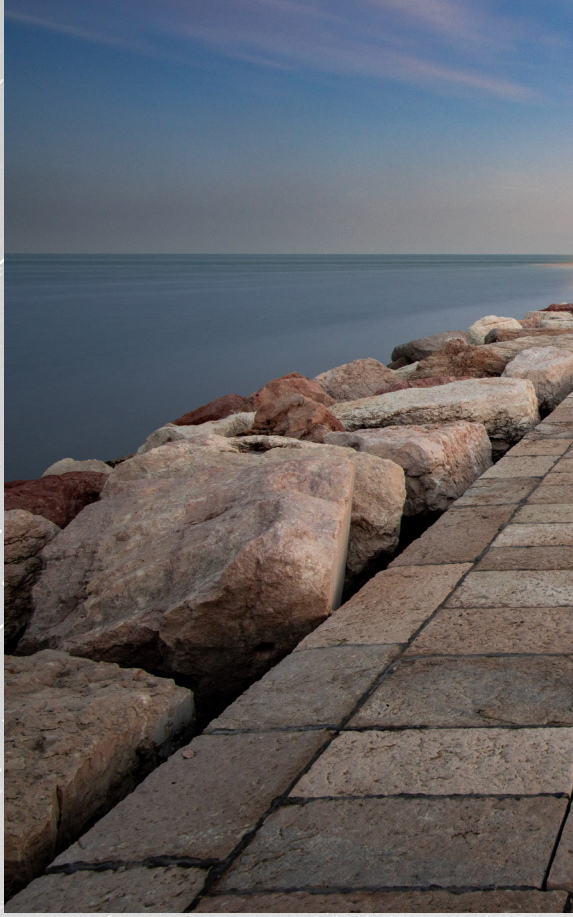

My Religious Psychopathology and the DSM 5

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THE DIAGNOSTIC STATISTICAL MANUAL

The Diagnostic Statistical Manual (DSM 5) is a "classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders" (DSM 5, p.xii). The many editions of the DSM have become a standard resource for psychiatrists, psychologists, counsellors, psychotherapist. However, it is contended that the DSM is an insufficient diagnostic tool in religious matters. In spite of this, a Harvard Medical team of psychiatrists, psychologists, and neuroligists compared the behaviour of Abraham, Moses, Jesus and Paul with the DSM-IV-TR (a previous edition) and concluded that each of them may have had psychotic symptoms such as schizophrenia, schizoaffective disorder and manic depression. They also went as far as suggesting that these psychotic symptoms served as an "inspiration for their revelations" (Murray et al, 2011, pp. 410-426). This may make some sense from a secular viewpoint. For example, St. Paul's described his intrapsychic conflict with some intensity:

> The good that I would, I do not; but the evil which I would not, that I do … O wretched man that I am! Who shall deliver me from the body of this death? (Romans 7:19 &24)

Further, St. Paul's "fool's speech" (2 Corinthians 11:16-12:10) included an out-of-body experience, a mysterious "thorn in the flesh", boasting of not being a fool and then calling himself a fool may seem to support the Harvard Medical team's conclusion. Our current involvement with other Christians may also lead us to wonder whether there may be something in this. We may be confronted by Erica Loberg's question:

Are there hyper-religious people walking around with schizophrenia or hypomania that don't even know it? (Loberg, 2012)

I am a lifelong practicing Christian and even a "hyper Christian" at times. Maybe I am "walking around with a psychiatric disorder that I don't even know about"? How much of my religion is delusion? In an attempt to investigate these questions, I will analyse my own life-story according to the DSM 5.

The DSM 5 is very careful to distinguish between religion and psychotic disorder:

> It is important to distinguish symptoms of brief psychotic disorder

> from culturally sanctioned response patterns. For example, in some religious ceremonies, an individual may report hearing voices, but these do not generally persist and are not perceived as abnormal by most members of the individual's community. In addition, cultural and religious background must be taken into account when considering whether beliefs are delusional (DSM 5, p.95)

The DSM-V also outlines a General Personality Disorder that has been assigned to religious patients:

> An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture … manifested as a pattern in two (or more) of the following areas - Cognition (i.e. ways of perceiving and interpreting self, other people and events); Affectivity (i.e. the range, intensity, lability, and appropriateness of emotional response); Interpersonal functioning; and Impulse control. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations … (and) leads to clinically significant distress or impairment in social, occupational or other important areas of functioning. (DSM 5, p.646)

PERSONAL ANALYSIS USING THE DSM 5

I feel like an outsider – even now in my 60s. Most people have a sense of being outside - but since birth I have had additional prompts to form an outsider script. Both my parents and grandparents were missionaries at Mt Margaret Aboriginal Mission in the outback of Western Australia. I was to be different – deriving enculturation from both Aboriginal culture (a shame-based culture), and from western evangelical Christianity (often based in guilt).

The shame negatively affected my quest for a healthy individual identity and guilt impeded my sense of wholeness. It didn't stop there. For more than 50 years my extended missionary family had fought for Aboriginal rights against a mainstream racist society that accepted active discrimination as normal. In 1959, at the age of eight, we moved from a harmonious mission community full of friends and family to a small country town in the southwest of Western Australia where my parents established a Bible College to train Aboriginal pastors. Back then, the town was deeply divided between Aboriginal and mainstream inhabitants. Soon after arrival, my classmates asked me whether I was a "native" (and other racist terms that I didn't understand) - only to find that the children they pointed at were already my friends. They advised not to mix with them because I looked "white enough" – advice I ignored.

I am very grateful for the benefits of a bi-cultural heritage but according to the DSM 5, my cognitive "ways of perceiving and interpreting self, other people and events" (affected by personal shame) may have already been compromised enough to cause "impairment in social, occupational or other important areas of functioning" (affected by personal guilt). The sense of being an outsider may have already placed me on the road to some sort of psychopathology.

My childhood cultural outsider status was further confounded by ethical questions of race. My parents encouraged me to forcefully confront racist statements in our school textbooks - like approval of Dampier's 1699 description of Aboriginal people as "differing but little from brutes" - and to stand against the theory of evolution – not only because it was anti-God and anti-Bible, but also because it was racist.

For example, the highly regarded anthropologist, Sir Walter Baldwin Spencer, claimed that the Anungu people of central Australia were the most primitive remnants of humanity on the evolutionary scale (Spencer & Gillen, 1899). Aboriginal people in our town suffered humiliation and many forms of exclusion - including being required to walk on the other side of the main street. We walked on both sides of the street and stood out as an unwelcomed force for de-segregation. This "fight for justice" was passed down to me.

In personal analysis, I have discovered that I can be hyper-sensitive to injustice and inappropriate and angry towards those I perceive as oppressors. The DSM 5 description of my affectivity (i.e. the range, intensity, lability, and appropriateness of emotional response) and impulse control was compromised and already set me at odds with other townsfolk and confirmed my status as an outsider.

Soon after the shock of moving to the Bible College, I began to suffer earaches and hearing loss - to the point where I had about 60-70% of the normal range of hearing and something I carried for the remainder of my life. I started to wet the bed. This isolated me further from mainstream culture and more dependent on the secluded and fervent evangelical Bible College environment where I lived. My worldview had a very different shape from classmates at school. The mission Sunday School taught me to stand up for what I believed because it was right:

> Dare to be a Daniel
> Dare to stand alone,
> Dare to have a purpose firm,
> Dare to make it known (Bliss, 1873).

Standing up for Jesus meant that I was prepared to stand alone and be different from the general population – in other words, outside the cultural "norms". I had the "purpose firm" and I "made it known" by evangelizing the lost - alienating me even further. My interpersonal functioning according to the DSM 5 criteria (p.646) across a broad range of personal and social situations did cause me distress that hindered my social functioning.

Bible stories I found normal would probably have been considered a little odd by other children in the town - Abraham's sacrifice of Isaac, Moses and the burning bush, prophets walking about unclothed and Lot's wife turning to salt, the four horsemen of the apocalypse and a lake of fire to destroy sinners. Stories of heroic missionaries such as William Carey, Hudson Taylor and Adoniram Judson encouraged me to reach for a destiny in God – anything short of that would be loss. All this could be described as well outside cultural expectations of my wider community.

During my teen years when the quest for personal identity is foremost, I felt a strong sense of shame possibly derived from Aboriginal enculturation that compounded by a strong sense of guilt from evangelical preaching and teaching about God's judgment. I was actively discouraged from participation in "culturally sanctioned response patterns" of mainstream culture (DSM 5). I was taught to "come out from among them and to be separate, saith the Lord of hosts" (2 Corinthians 6:17). Our rules included modest dress (read "out of fashion"), no Hollywood pictures, no swimming on Sundays, no swearing, no playing cards, no participation in school socials and dances, and no alcohol or tobacco. Instead of participating in country sport, I attended

all of the church meetings on Sundays. Out of step with mainstream Australian culture, I tried to obey the childhood injunctions to "be holy" (1 Thessalonians 3:11-13) and "out and out for Jesus". For me it was not enough to be a nominal Christian, I was to be unique and different because I was a believer with a destiny – something I never really felt.

My outsider status extended to broader sociocultural areas. I can remember my feelings during my cultural drift into mainstream culture when completing secondary education in the city and the feeling the widening gap between me and my Aboriginal family and friends. While at the city school, my Aboriginal friends were going in very different ways. When we met we seemed to have less and less to talk about (except for old stories and memories) and less and less in common. More and more I was the "white guy" who was excluded from full participation with my Aboriginal mates – I was an outsider with outsiders. This outsider status makes a DSM 5 diagnosis of "delusion" difficult. I belonged to various cultural groups – missionary, religious, mainstream, secular and Aboriginal – and my responses would probably fail a DSM "culturally sanctioned response" test of any one of those cultural norms. What was normal in one culture could be considered delusional in another.

My encounter with delusion became real at the age of ten. My father, through overwork and stress of founding a Bible College with inadequate resources, suffered a nervous breakdown for which he was hospitalized. This was followed by a series of episodic relapses. I observed him holding concrete delusions (such as the meaning of letters on a number plate) that he interpreted as keys for Aboriginal evangelism.

> Possible psychiatric assessment: Technically, this would be described as a delusional percept: that is, a normal perception (a number plate) with a delusional interpretation (implications for Aboriginal welfare and evangelism) (based on Sims, 2007).

Given his zeal for Christ, my father expressed delusions that centred on a preoccupation with religious subjects. More precisely, he suffered from "delusion with religious content" - making manic sentences with two or more unrelated topics; obsession with his non-Christian father's conversion; and making inapropriate statements in front of him. Even though the line between psychotic delusion and faith had been compromised, the threshold was very clear to the family. We could tell when our highly intelligent father needed a rest. We unconsciously followed an "incongruity test" proposed by Lieberman, et al (2006, p.199):

> The behaviours were "not within the expected beliefs for our background, culture, education, and known experiences of religion, and because they were incongruous".

We recognized that "incongruity" rather than "religious delusion". Even though he spoke a lot about God, we saw a causal relationship between his workstress and his initial breakdown. Ultimately, he was able to have a very fruitful ministry with the occasional help of medication, rest and treatment that was in keeping with appropriate psychiatric medical care.

However, further education during the late teenage "era of doubt" did make links between religious psychopatholgy and delusion. For example, Freud (1927) explained religious "delusions" of the common man as "amentia" (a state of blissful hallucinatory confusion) that he described as patently infantile and comprised of a system of wishful illusions that disavowed reality. I began to wonder whether my father's unwell religious delusions were pathological and caused by religion. Later postgraduate studies included reading blunter assertions such as Karl Marx:

> Religion is the sigh of the oppressed creature, the heart of a heartless world, and the soul of soulless conditions. It is the opium of the people (Marx, 1844).

Growing up, my parents taught me to be suspicious of psychology and psychotherapy because it was a "false gospel". The war between religion and psychology is not new. In a 1937 essay, Sigmund Freud (1939, cited by Sims, 2007) stated that monotheism was a delusion that was supported by the "Schreber Case" (Freud, 1911). This case involved a highly respected middle-aged German judge who came to believe that God was turning him into a woman (a condition that would not be considered abnormal these days!).

Schreber's (1903) description of his divinely inspired gender confusion became an influential case study in psychological history – especially given its linkage between religion and delusion. Contemporary examples of religiously motivated delusions can also be used to confirm this view – such as the auditory religious command hallucinations that motivated a mother to kill all of her eight children in Cairns because she interpreted a dove's call as a sign to "cleanse her house" and to "kill her children in order to save them (Branco, 2017); and John Lennon's murderer's frustration at Lennon's claims to be more popular than Jesus (Gaines, 1987).

However, these examples do not prove Freud's assertions of delusion being caused by religion. Although religion may have been one of the motivating factors, it does follow that murderous intent was caused by their religion. Instead, it was their incongruous delusions that was out of step with their cultural norms (Lieberman, et al, 2006, p.199). The DSM 5 could be used far more effectively to diagnose other mental health conditions rather than attributing religion as a causal factor. Nevertheless, assertions of the causal link between relgion and delusion in individual cases like these did cause me to wonder.

More compelling evidence of the harmful delusional effects of religion was supplied by historical investigation of religious societies. While religion may not have a causal effect on an individual level, widespread violence in the name of religion such as the massacre of Muslims during the Crusades, the Inquisition, contemporary fundamentalist Islam and the Jonestown group suicide may point to "religious delusion".

During my childhood, I observed missionaries that were a little abnormal – and some even quite odd – in their zeal to blot out Aboriginal culture in the name of religion. They may have been on a delusional continuum or merely in line with mainstream Australian xenophobia. Eventually, in my early 20s, I saw that Freudian and Marxist generalizations were just that. I perceived many other delusions in western materialism – whether or not Freud included them as pathological conditions. I decided my quest for life's meaning consisted of more than a dry secular life pursuing materialism, prestige and hedonism (Frankl, 1946/2009):

> I tried the broken cisterns, Lord,
> But, ah, the waters failed,
> Even as I stooped to drink they fled,

> And mocked me as I wailed.
> Now none but Christ can satisfy
> (Beven).

I pursued my own spiritual journey and could even been a "hyper-Christian". I became active in my local church and went into theological training to prepare for spiritual service. I wanted to fulfill God's destiny for my life which led me to missionary service in Brazil. I actively listened for God's voice. I told myself that I was willing to do anything for God:

> There are plenty of people around the world that have strong beliefs and connections with God; people are even willing to die for their God. So is that the definition of "hyper" religion – a willingness to die for God? Does a person have to have a mental illness to be considered a hyper religious individual? Or perhaps there is no relationship between hyper religion and mental illness (Loberg, 2012).

It could be argued that I received a strong "missionary script" in childhood that predisposed me to hyper-religion. However, there is nothing in the DSM 5 that confirmed that my pursuit of personal destiny was outside the normal range even though I heard voices in religious ceremonies that fitted in with (missionary) cultural expectations. Nor does the DSM 5 explain the causes of my religious and spiritual zeal.

Nevertheless, looking back on my decade in missions, I sometimes wonder whether we missionaries were all on a spectrum of group delusion. The ICD-10 (1992) includes a classification of "shared and communicated delusion" between two or more people. While we did not exhibit psychosis attributable to DSM 5 criteria, there were times that our group-think may have bordered on delusion. Like other expatriate groups, our strong, shared worldview was often at odds with both our home cultures and our host country. However, our religious missionary group-think may have exacerbated our "delusions".

Looking back on it, I now recognize greater explanatory and diagnostic power in Lifton's (1969) eight methods of thought reform – milieu control, mystical manipulation, demand of purity, cult of confession, sacred science, loaded language, doctrine over person, and dispensing of existence (Milnes, 2017, pp. 48-51). There were certain cult-like factors that were not good for my mental health and strengthened my outsider script. My hyper-religiosity and desire to hear God's voice led me to submit to things that were against my own volition and better judgment. My resolve to "walk humbly with my God" (Micah 6:8) became my misguided attempts to do God's will by submitting to the will of others to the point where each of Lifton's methods of thought reform affected me. For me, the mission "group think" became a "delusion". My sources of self- efficacy were well-described by Bandura's (1986; Colledge, 2002, pp. 224-226) social cognitive theory containing the elements of enactive attainment, vicarious experience, verbal persuasion, physiological state, efficacy information, enactive information, vicarious information, persuasive information and physiological information. My contention here is that Lifton's theory of thought reform and Bandura's social cognitive theory has far greater explanatory power than diagnosis following the DSM 5.

On return to Australia, I have pondered about the destiny that I was taught to pursue as a child. Was my missionary call a "delusion"? I felt guilty that I had failed and was ashamed to have achieved so little. I had often felt out of step with my missionary colleagues - an outsider even with outsiders. Perhaps the most helpful thing within the DSM 5 for me is the brief and rather vague paragraph entitled Religious or Spiritual Problem (under Other Conditions that may be a focus of clinical attention):

> This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution. (DSM 5, p.725)

This DSM 5 category allowing for "clinical attention to religious and spiritual problems" has been a large part of my clinical formation and practice. I have arrived at some philosophical conclusions that vary from both Freud's and my parents' view of psychology, emotional healing and spiritual growth in my personal journey. I have also found use for secular resources as well as the Scriptures in my practice. As a practicing psychotherapist and specialization in Transactional Analysis, I have discovered explanatory power for clients presenting with distressing religious experiences, questioning faith and failing their spiritual aspirations. I use the DSM 5 in my clinical work but I find that it contains little value in diagnosing religious delusion – contrary to the over-confident assertions of the Harvard Medical team Murray et al, 2011, pp. 410-426). Psychotherapy and counselling from a Christian perspective can assist those who have religious and spiritual problems rather than contribute to delusion.

In conclusion, I wish to draw attention to the following points arising from a personal analysis in the light of the DSM 5:

- First, the DSM 5 is an inadequate diagnostic tool in religious matters. There is better assistance from:
  - ◊ The Scriptures and hymnody explain the spiritual and religious elements of the human condition.
  - ◊ Psychiatrist Andrew Sims (article in this edition),
  - ◊ Leiberman et al work on schizophrenia (and other disorders),
  - ◊ Lifton's categorization of mind control,
  - ◊ The ICD-10 classification of mental and behavioral disorders,
  - ◊ Frankl's meaning of life,
  - ◊ Bandura's social cognitive theory, and
  - ◊ A personal spiritual journey.
- These cited resources are just a few of a rich literature on "religious delusion" – or better described as "delusion with religious content".
- Second, Christian counselors and psychotherapists should understand the falsity of Freud's generalizations about religious delusion – and over-confident diagnoses of biblical characters and religious experience based on a faulty interpretation of the Scriptures and the DSM 5.
- Third, Christian Counsellors and Psychotherapists are better able to understand the "cultural context" of people experiencing religious and spiritual issues – because,

like them, we are also "outsiders". We are in a strong position to understand the presentations of "incongruity of behaviour" (Lieberman et al) and also discern when the behaviours are part of a spiritual journey.

- Fourth, Christian counsellors' own faith journey can illuminate the pathway of psychotherapy when we use them in analysis. I think I may have resolved a lot of my outsider cultural issues and adapted to partial hearing by the use of aids. I have largely come to terms with my sense of shame (affecting my identity-formation) of not achieving acclaimed destiny but there are times when my sense of guilt (affecting my sense of wholeness) and regret (failure to achieve) reminds me of my brokenness. On a positive note, I have found that this faith journey assists me to empathize and assist clients who are battling religiously and spiritually.

- Fifth, my views of religion and psychology have undergone a transformation with my reconciliation of ideas. For me, my early script suspicion of psychology and psychotherapy has been largely re-decided during my training as a psychoanalyst. However, my journey of integrating faith and practice continues.

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