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CHAPTER 2.2

Christianity and Psychiatry

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Approximately 2.2 billion people, or about a third of the world's population, call themselves Christians. Christianity and psychiatry share a rich history, which continues to evolve. This history has been shaped by both culture and the diversity of Christian traditions [1, 2], which comprises, in addition to the major Protestant, Catholic and Orthodox traditions, thousands of smaller denominations. Here we will consider what most would agree is central to the Christian worldview; what this world view implies about mental health, mental illness and its treatment; sources of tension at the interface between psychiatry and Christian faith; and opportunities for constructive engagement.

2.2.1 THE CHRISTIAN WORLDVIEW

Christians believe that an intelligence beyond the universe created it. Human beings, formed in God's image, were originally in intimate communication with their Creator. However, their rebellion led to estrangement, and the presence of illness in the world. God used the lives of prophets and others to call people back into relationship with him, and ultimately revealed himself in the life, death and resurrection of his son Jesus. Knowing and following Jesus is transforming of a person's attitudes, experiences and way of life in the direction of becoming more generous, compassionate, and forgiving.

Like Jews and Muslims, Christians believe that God's Word is found in an authoritative book (the Bible). They also believe in a God who speaks (though they may differ in how), and listens to prayer. Unlike Eastern religions, they believe that history is linear, rather than circular.

Worldwide, diversity within Christianity reflects differences along at least four axes: (1) Understandings of how to interpret the Bible – from fundamentalists who believe in a six day creation to liberal, or 'mainline' Christians who focus more on social and ethical imperatives to be drawn from its teachings; (2) Expectations of engagement in supernatural activity of God, from those who believe in praying for miracles to those who believe that, if they occurred, these were limited to biblical times; (3) Styles of worship, ranging from highly structured, formal liturgies (e.g. Catholic, Orthodox) to spontaneously expressive

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forms (e.g. Pentecostal); (4) Predominance of emphasis on correct belief (many evangelicals), vs. spiritual experience (charismatics), vs. social action (liberal Protestants, Catholics), vs. spiritual practices (liturgical traditions).

2.2.2 MENTAL HEALTH

Unlike dualists and Eastern mystics, Christians regard the body and the mind as distinct but inseparable. As a result, they are generally comfortable with contemporary psychiatry's biopsychosocial approach to human problems. They also acknowledge that optimal human functioning includes adaptive capacities of the individual to reflect, and regulate emotion. However, Christians believe that human flourishing depends on more than optimally functioning biological or psychological processes, and is not achievable in a state of detachment. Rather, optimal adaptation is relational, and directed toward what is most important in life. It entails having a solid identity, realistic hope, meaningful activity, authentic relationships, a mature moral life, and a balance between autonomy and respect for authority. These emergent elements of a fully effective life are only intelligible against a 'horizon of significance' [3], which for a Christian is his relationship to God.

Christians believe that it is best for human beings to live as they were created, rather than as they might independently choose, and that this has behavioral implications – for example, Christians see a link between sexual intimacy and commitment. Conservative and liberal Christians may interpret differently whether some biblical teachings (such as those regarding homosexuality) are culturally bound, and hence less binding than those teaching ethical principles such as social justice.

2.2.3 MENTAL ILLNESS

Hebrew and Christian texts describe several forms of major mental illness, including King Saul's mood swings, Nebuchadnezzar's psychosis during which he ate grass, and the harm self-inflicted by the deranged man whom Jesus healed. Biblical authors typically regard these as out of the individual's control, and a cause of suffering. Consistent with medical knowledge of the time, some individuals who would now be identified as mentally ill were regarded in biblical times as demonically possessed.

Contemporary Christians generally accept standard definitions of mental disorders. However, more conservative believers may question their application, based on their particular readings of scripture. For example, they may wonder whether the category of possession has been adequately considered in a patient with dissociative symptoms (Roman Catholics have established a procedure for systematically evaluating medical and other evidence before referring the case to an ordained exorcist). Depression, anxiety and compulsive religious practices can also sometimes be difficult for Christians to distinguish from spiritual failure, since their faith promises joy, peace and freedom.

Christians share with positive psychology a greater emphasis on what enhances human flourishing than on psychopathology. For example, they recognize the importance of successfully accomplishing the universal moral tasks of developing moral commitments, making moral decisions, implementing these decisions, assessing the correspondence between their ideals and behavior, dealing effectively with moral failure, and developing

morally admirable character traits, or virtues [4]. As corollaries of this, they may see moral distress as worthy of clinical attention, and personality disorders as deficits in morally admired character traits, or virtues [5], and therefore eligible for spiritual intervention. Similarly, they regard existential concerns surrounding identity, hope, meaning/purpose, morality and autonomy in relationship to authority as reflecting human needs for spiritual answers.

The emphasis of Christians on a larger context also casts a different light on distress as a defining criterion of psychopathology. For example, they see painful conditions such as the 'Dark Night of the Soul' as potentially conducive to spiritual growth. The sixteenth century Spanish mystic St. John of the Cross described the dark night of the soul as an experience of disenchantment with a person's usual spirituality in which God may seem distant, meditation forced and prayer empty. The individual may struggle to find gratification elsewhere, question God, or become confused by his attempts to understand. However, if this dark (in the sense of obscure) process is marked by a desire to love God, it can represent growth taking place in that relationship in two phases, at an unconscious level. In the first phase, which St. John termed the 'dark night of the senses', the individual becomes disenchanted with its usual activities – as a log is blackened by a fire. Emmer [6] (2004) summarizes the three indicators of this phase as follows:

1. The soul finds no satisfaction in either the things of God or in other creatures.
2. The soul is troubled by the impression that it has turned away from God; it interprets its distaste for the things of God as a falling away from Him.
3. The soul finds itself no longer capable of meditating and using the imagination in its prayer, despite fervent attempts to do so.

During the second, 'dark night of the spirit', the soul is challenged to let go of core, self-centered assumptions and commitments that prevent union with God. In St. John's imagery, the log is not only blackened, but consumed. Eventually, the suffering caused by raw sensitivity to the world leads to the awareness of a path. In St. John's words, 'Undetected I slip away – my house, at last, grown still.' While in the dark night of the soul an individual loses the ability to enjoy God and life, but unlike in classical depression, he still feels a strong desire to know and to please Him. Gerald May also notes that while the dark night of the soul may be complicated by depression, it is typically not accompanied by a loss of effectiveness, a sense of humor or compassion for others [7, pp. 84–92].

Christians also see the sacrifice of one's own comfort or self-interest as essential to Christian discipleship in an unjust world. In Jesus' words, a person must lose his life to save it. This challenge is sometimes understood by non-believers as masochism, and distorted by believers to mean a denial of healthy self interest for the sake of suffering itself.

Clinicians unfamiliar with Christian practices such as speaking in tongues (particularly common in the developing world), or hearing from God may confuse these with psychopathology. It can help for them to confer with more experienced colleagues, or with members of a patient's faith community in order (for example) to distinguish depression from the disillusionment with God, ritualized religious observances of scrupulosity from OCD, or psychosis from the normative experience of hearing God's 'voice'. A clinician who is familiar with the Dark Night of the Soul would include this in his differential diagnosis of depression in a Christian patient. One who is familiar with the ritualistic nature of some spiritual practices (such as chanting, or saying the rosary) will include these in the

differential diagnosis of OCD in a scrupulous patient within a liturgical and/or monastic tradition, and be wise to ask members of the patient's religious community if the behavior seems excessive to them. And a clinician who is familiar with the way that many Evangelical and charismatic Christians talk of hearing from God as an everyday (not usually audible) experience will ask whether this is what is meant when a patient says that God told him to move in a certain direction.

2.2.4 TREATMENT

Jesus healed the sick, including the deranged, and cared for the disadvantaged. Some Christians have since mistreated individuals whom they regarded as possessed, but beginning in medieval times, religious institutions such as monasteries have provided the mentally ill with humane care. Benjamin Rush, the founder of the American Psychiatric Association, worked during the Moral Treatment period to provide humane care for the mentally ill, accessible to the poor, under the motto 'Take care of them and I will repay thee' [8]. Within the last century, institutions such as Pine Rest Christian Hospital in Michigan and numerous clinics have emerged to provide psychiatric care within a Christian context [9].

Faith can play an important role in the treatment of Christian patients in several arenas, both as a source of distress and as a resource. One arena is patients' disappointment with themselves. They may experience guilt for failures 'in thought, word and deed' but find themselves unable to accept the forgiveness that their faith offers. Clinicians can help them to understand whether they need to address problematic repetitive behavior, or a sense of unworthiness rooted in their emotional past; reassess their understanding of their faith; or find a better way to practice it. Clinicians can also help them understand the issues evoked for them by judgment coming from church authorities over abortion, divorce, or other proscribed behavior.

A related arena is patients' disappointments with others, which can give rise to anger, difficulty forgiving, and guilt over these emotions as un-Christian. Jesus' statements about the importance of inner attitudes (lust as the same as adultery, and hatred as murder) can lead some Christians to feel too ashamed of these feelings to acknowledge, express and explore them in therapy. Therapists may need to help them recall other scriptures that emphasize the importance of controlling the expression of desire, and of openly examining all of the contents of one's heart. At the same time, therapists of Christian patients need to use caution in encouraging anger, since these patients may hear this as conflicting with Jesus' commands to forgive, and to love their enemies.

A third arena is disappointment with God. Believers who expect God to act in their everyday lives are particularly vulnerable to becoming disillusioned when their prayers for healing, guidance or protection seem to go unanswered. A history of trauma or neglect by authorities who should have protected them earlier in life may lead them to experience God in the same way. Clinicians can help them see such connections, remind them that many biblical persons of faith strongly questioned God, and acknowledge that feeling unable to trust God can be for them a significant loss.

A fourth arena is moral decision-making. For many serious Christians, the prime criterion in determining the choice of a career, or deciding a marriage partner, is whether it is God's will. They may struggle in treatment to weigh their desires for personal gratification, their family and other obligations, and their understanding of what it means to follow Jesus. Therapists can sometimes help them think through these issues more dispassionately than other figures in their lives, with a view to how their emotional vulnerabilities figure in their choices.

Yet another arena is the frank distortion of faith by emotion. Depressed individuals who experience guilt in religious terms may feel that only judgmental scriptures and teachings apply to them. Anxious patients may worry, despite what their pastors tell them, that they have committed the unpardonable sin. Psychotic and other patients may believe that God is directing them to do, or to avoid doing what they seem disinclined for other reasons to do, or avoid. Therapists need to respect the importance of faith to such patients, and while eschewing the role of religious authorities, look for ways to help them examine the influence of their emotions on their understanding of their faith. They may also need to help them find resources that can help them approach these distortions from within a religious context.

Finally, distorted theology can reinforce psychopathology in some individuals. Branches of Christianity that advocate an abstinent life style, teach the complete unworthiness of human beings, or emphasize that women should be subservient to men may contribute to the difficulty that their members may have in finding appropriate expressions of desire, accepting themselves as having worth in the eyes of God, or accepting the teaching that in Christ there is 'neither male nor female'. Therapists can help such patients to examine for themselves whether the teachings they have received are a reasoned interpretation of the scriptures, and whether there might be alternative points of view worth considering.

Generally speaking, the worldview of Christian patients shapes therapeutic work with them in at least three ways. First, as suggested above, Christians regard personal improvement, whether through psychotherapy or psychopharmacology, as only a relative good. Psychological insight and the support of a therapist are not enough to make one fully happy. Rather, to have a sense of their worth, humans need to love, and be loved by others, and are helped to do so by experiencing God's love. Furthermore, to deal with their failures and those of others, they need to forgive and experience forgiveness, made more possible by experiencing God's forgiveness. What implications does this have for treating a depressed Christian patient, for example? A therapist would want to explore whether there was a spiritual component to his depression (e.g., guilt or feelings of worthlessness expressed in the terms of his faith). If so, he would want to know whether his faith was a source of comfort or distress, and how he could bring its resources (e.g., related to feeling loved, or forgiven) to bear on the patient's struggles.

Second, as noted above, Christians recognize a call to self-sacrifice – to emptying themselves of their own selfish wills by 'bearing the cross', the instrument of their own execution – in order to give themselves fully to God and the service of others. Models for this include Jesus, the martyrs of history, and Martin Luther King, Jr. in our own time. Depressed and anxious individuals, particularly those who have been forced to submit to an abuser, can experience this as a heavy obligation, and as a threat to attempts to rebuild a damaged sense of self. How can a therapist help such a patient who is struggling, for example, with whether they have a Christian duty to accommodate a demanding spouse? One way is to help them remember that while the Christian scriptures emphasize that suffering for a good cause can result in personal growth, they do not endorse it for its own sake, and in fact call for joyful living. Another way is to help them understand that Jesus' command to love others as oneself implies that one ought to love oneself. This provides a basis for exploring together whether

the patient's sacrifice would be helpful to its object and to themselves, and chosen freely, rather than out of habit or a distorted sense of self.

Third, Christians' disappointed expectations for healing, or for a better life can become significant issues in their treatment. A bereaved individual, a depressed patient, or survivor of clergy sexual abuse may feel guilty for losing his faith, angry with God for allowing his pain, or in despair at losing a formerly valued relationship with God. The therapist of such patients faces the challenge of validating and exploring their negative thoughts and feelings, while keeping open the possibility that they will be able to find in their faith a positive resource. As noted above, patients who are asking for help in their struggles with God may find it helpful to consider examples in the scriptures of disappointed believers who voiced similar feelings to God.

While Christians recognize the importance of including the spiritual dimension of life within any therapist's frame, they resist the instrumental application of spiritual practices such as prayer or meditation to promote health apart from the tradition out of which they grew, since this can easily distort their meaning within that tradition [10]. Health may be a benefit of faith and even the occasion for it, as for many individuals healed by Jesus. Yet more is at stake in pursuing faith than its therapeutic benefits. The fact that marriage is associated with better health outcomes is not reason enough to recommend that patients marry. Both spiritually oriented therapists, and 'health and wealth' preachers can forget that central to following Jesus is losing life in order to find it.

Therapists who encourage spiritual practices for Christian patients also need to recognize the dangers of becoming spiritual authorities for their patients. These dangers include losing focus on the psychological aims of their work, distorting the therapeutic frame so that for example transference-based interpretation is not feasible, offering direction in areas where the therapist may not be expert or competent, and failing to help patients work through their difficulty engaging with more appropriate sources of spiritual support.

How then can therapists help Christian patients make best use of the guidance and resources of their faith in dealing with issues that arise in treatment?

One way is to examine with them exactly how they are deciding on a direction, whether from relying on the scriptures, on an inner sense of God's direction or on the teaching of the church. A believer with same sex attraction may believe from reading scripture that it is wrong for him to act on these feelings. An abuse survivor may feel a duty to forgive the perpetrator. Partners in a difficult marriage may believe God wants them to do everything they can to work out their differences. Believers can find these senses of direction helpful, but they may also find them unreasonable, and a source of distress. Therapists can help them distinguish clearly what they believe their faith teaches, what they themselves feel is right, and how they can resolve discrepancies – for example, by learning more about differing Christian approaches to homosexuality. Throckmorton and Yarhouse [11] describe such a process in their sexual identity therapy, a practice framework for managing sexual identity conflicts. Their recommendations provide conceptual and empirical support for clinical interventions leading to sexual identity outcomes that respect the personal values, religious beliefs and sexual attractions of affected individuals.

Christians may also find resources in their faith for helping them to live in accordance with what they have come to believe is best. Prayer, worship, service and participation in other 'spiritual disciplines' can offer what human relationships cannot: ultimate purpose, forgiveness, acceptance, and connection with their Creator [12]. While these can be difficult to apprehend scientifically, and attempts to study effects of intercessory prayer on healing

have drawn criticism [13–15], a growing body of research correlates religious activity [16], hope and purpose [17] with measures of well-being. An important focus of the treatment of an individual who has experienced these benefits may therefore be to address obstacles to accessing these. These may include disappointment with a pastor; anger at God; a rigid, judgmental childhood church experience; or barriers presented by depression, anxiety, and problematic personality traits.

2.2.5 SOURCES OF TENSION

Tensions continue to exist on several levels between Christianity and psychiatry. These tensions have their roots in (a) gaps in knowledge, (b) historical developments within psychiatry, and (c) ongoing biases and misunderstandings, and (d) differences in emphasis or approach.

Some secularists, notably the evolutionary biologist Stephen J. Gould, have contended that religion and science are so different in their purview as to be 'nonoverlapping magisteria' [18]. It is true that Christianity and psychiatry emphasize different ways of knowing: Christians use scripture, and their experience of God, while psychiatrists emphasize scientific observation and clinical judgment. It is also true that tension sometimes arises because both psychiatry and Christian faith suggest competing answers to many of the same questions, such as what is best for individuals and societies, how to deal with failures to live up to ideals, and the relationships between human beings and larger realities. Yet it is important to remember that full answers to many human concerns are beyond the reach of either science or faith. How exactly did human beings come to be as they are? What accounts for evil? What purpose can be found in adversity? Interdisciplinary research that takes both kinds of knowledge into account is growing. One example is forgiveness [19], which in addition to being a quintessentially Christian ideal has become the subject of investigation into its essential elements, measurement, antecedents, interpersonal and psychological effects, and usefulness in therapy. Four stages of forgiveness are: (1) acknowledging deep and unfair hurt; (2) wishing that one's 'enemy' suffer; (3) beginning to see the 'enemy' in a new light (for a Christian, as another child of God), and (4) reconciling, which depends on both parties. Questions now being asked concerning the relationship of forgiveness to psychological and theological theory, as well as to its potential benefits and drawbacks in practice. Another is the virtues [20], which have come to be studied not only from theological and philosophical perspectives, but also from the perspective of positive psychology for their origins and functions as ingredients of human flourishing. A third example is love [21], which is being studied in similar ways. Yet to date, such collaborative scholarship is the exception. More often, investigators choose one or another paradigm with which to fill in gaps in their understanding.

The hostility between science and religion that developed during the Enlightenment found expression in Freud's attacks on Christianity as an immature form of wish-fulfillment. Subsequent analysts such as William Meissner and Ana-Maria Rizutto have since modified Freud's teaching about how faith develops, but many Christians came to regard psychoanalysis as anti-religious. For years, academic psychiatry either neglected spirituality, or tended to present it in a negative light [22]. On the other hand, Freud's longest correspondence was with a Swiss pastor and psychoanalyst. Their dialogue continues to be recognized by the annual Oskar Pfister Award, conjointly sponsored by the American Psychiatric

Association and the Association of Professional Chaplains and given to an individual who has made outstanding contributions at the interface between psychiatry and religion. Pastoral counselors and chaplains have long since embraced psychoanalytic insights, incorporating many of them into Clinical Pastoral Education (CPE). Christians have often felt less directly threatened by the growth of descriptive and biological psychiatry, rarely taking on its proponents directly over such questions as whether depression is an illness, a problem in living or a lack of faith [23].

Several recent developments have led to a greater appreciation of spirituality within medicine and psychiatry. Twelve Step programs such as Alcoholics Anonymous (AA), with Christian and Jungian origins, are standard interventions in treating addictive disorders. Participants in AA, which describes itself as a spiritual approach, acknowledge that they are powerless over their addiction, turn themselves over to a Higher Power, take a 'fearless moral inventory', confess to another person, make amends, and take steps to be of service to others. Palliative care now includes spiritual assessment and care among its goals of treatment at the end of life [24]. The growth of integrative medicine has led to the use of spiritually oriented approaches such as mindfulness and meditation, including evidence-based psychiatric treatments such as dialectical behavior therapy (DBT). Spiritually oriented interventions, some of them explicitly Christian, have gained in acceptance [25]. These include spiritual direction, mindfulness, spiritually oriented cognitive behavior therapy (CBT), meaning centered and forgiveness promoting psychotherapy.

Scholarly efforts to integrate Christianity and psychology have grown during the past 50 years. Currently, seven doctoral programs in clinical psychology in the U.S. at Christian institutions of higher learning accredited by the American Psychological Association encourage students to explore connections between the insights of psychology and the wisdom of their faith. They attempt, at a scholarly and practical level, to integrate Christian truth with psychology in courses such as 'Social, Cultural and Spiritual Foundations of Mental Health' and Theological Anthropology'. Similar programs now exist around the world. For example, the Moscow Christian School of Psychology offers a three-year curriculum focused on the treatment of children, adolescents and families. Two professional organizations, the Christian Association of Psychological Studies (CAPS), which hosts international conferences, and the almost 50,000 member American Association of Christian Counselors (AACC), and two journals, *The Journal of Psychology and Theology* and the *Journal of Psychology and Christianity* concern themselves with these issues. The Psychiatry Section of the Christian Medical and Dental Association, with a membership of approximately 200 psychiatrists, meets every year at the Annual Meeting of the American Psychiatric Association to consider ways of relating and integrating faith and psychiatric practice.

Some biases that psychiatry and Christianity have toward each other persist, with attendant mistrust. Many conservative Christians (and adherents of other faiths), aware that psychiatrists are on average less religious than the general public, fear that a secular therapist will either undermine their value concerns (for example, regarding divorce, homosexuality or abortion), or fail to help them incorporate these into their treatment. Many Christians also struggle with whether it is right to take an antidepressant, rather than to pray for more faith. A few contend that biblical counseling is a preferred alternative to treatment by a mental health professional [26]. Christians may ask clinicians what their experience or attitude is toward their faith, and psychiatrists need to develop honest, therapeutic responses to such questions. This is more difficult when psychiatrists who see troubled Christians, particularly those who have been unable to find what they need in their

religious communities, have developed impressions of Christianity as judgmental, masochistic, misogynistic, homophobic and monolithic. If they are unfamiliar with the wide range of belief and practice among Christians, they may be tempted to try to rescue these individuals from a dysfunctional set of beliefs, rather than to look for ways that their faith and its mature representatives could be resources for their growth and healing.

2.2.6 OPPORTUNITIES FOR CONSTRUCTIVE ENGAGEMENT

Distinguishing the roles of therapist and pastor is perhaps the first step toward constructive engagement. Though broad in its purview, psychiatry is a specialty of medicine, and a psychotherapist serves a different social role from that of a pastor. The psychiatrist's duty to treat mental disorders, as defined by a consensus of secular professionals, mandates that he not substitute his own religious or spiritual 'commitments or religious/spiritual ritual for professionally accepted diagnostic methods or therapeutic practice' [27]. In many communities Christian pastors provide considerable help for individuals with such disorders [28]. However, their aim is to enlist God's help for individuals struggling to become more whole, on behalf of a caring community. Both a spiritual director such as a pastor and a psychotherapist may explore limiting conflicts and potential solutions, but the primary aim of the spiritual director is to foster growth in the individual's relationship to God rather than to relieve symptoms, improve functioning or even change character [29].

Viewed from the mental health side of the natural boundaries between them, Christian faith can offer important resources for patients dealing with existential concerns in areas such as identity, hope, meaning/purpose, morality and autonomy in relation to ultimate authority [30]. Viewed from a Christian perspective, mental health treatment offers relief of suffering, and psychological help for individuals in addressing obstacles to spiritual progress – for example, an inability to forgive, accept grace or trust related to unresolved trauma. Consider briefly the implications of engaging both faith-based and psychiatric perspectives in diagnosis, treatment and delivery of care.

2.2.7 DIAGNOSIS

Christians can provide psychiatrists with contextual information about religious beliefs and cultural practices that can help them understand whether an individual who claims to hear God's voice is psychotic, or whether his sense of guilt is a symptom of depression. Similarly, psychiatrists can provide expertise on the nature of psychosis or depression that can help Christians understand whether patients who express their symptoms in religious terms need somatic treatment as well as spiritual support.

Christian categories may provide a better way of conceptualizing certain phenomena than psychiatric categories of disorder. This may be true for sub-syndromal or sub-threshold forms of anxiety or depression that are related to existential or spiritual concerns [31]. It may also be true in the case of personality disorders. Cloninger [5] proposes that patients with personality disorders can be most clearly understood as having deficits in the coherence of their fundamental assumptions and schemas about life – i.e. deficits that can be considered spiritual. This proposed change is based on both the history of well-intentioned but unsatisfactory attempts to classify personality disorders without reference to virtues and

vices, and on modern needs for improved treatment planning. A patient's religious or spiritual outlook also shapes, and is shaped by, post-trauma symptoms in a number of ways. These include the influence of religion and spirituality on worldview; religious or spiritual coping strategies; an individual's perception of the moral meaning of the traumatic event; and social forces that contextualize the traumatic event.

2.2.8 TREATMENT APPROACHES

Psychodynamic principles, some of which can be found in the Psalms and the writings of Paul, have long informed much Christian pastoral counseling and psychotherapy. More recently Christians who practice, study and teach psychotherapy have more formally incorporated familiar spiritual interventions (e.g. regarding 'knowing the truth', and having one's 'mind transformed') into cognitive behavioral (CBT), forgiveness promoting, and the integrative therapies described by Richards and Bergin [32], and Pargament [33]. They share with humanistic and existentially oriented clinicians an emphasis on meaning and the intrinsic value of the individual. Secular clinicians are now more aware of the importance of helping patients make use of spiritual resources [21] and of effectively addressing spiritual problems in psychotherapy, including through referral [31]. The potential for collaboration is particularly evident in efforts to help patients by combining spiritual direction and traditional psychotherapy [29].

2.2.9 DELIVERY OF CARE

Where misunderstandings and bias have lessened, clinicians and Christians have developed several models of delivering integrated mental health and spiritual care: through a single individual; through a religious individual working in a secular institution; and through a mental health clinician working in a faith-based organization.

An individual therapist can incorporate many of the spiritual treatment approaches referenced above into his work with a believing patient, so long as he is aware of potential tensions inherent in the dual role of priest and healer, and of the importance of a community in healing fully. He is most likely to be effective if both trusted by local Christians and respected by the wider medical and mental health communities.

Arguably, most spiritual care for hospitalized patients is provided by religious representatives (chaplains and clergy) working in secular institutions. In the U.S.A., the Joint Commission for Accreditation of Health Care Organizations (JCAHO) sets standards for such care. Typically, hospital-based chaplains are ecumenical, able to serve both Christians and non-Christians, although some conservative Christians prefer to use their own pastors. In addition to explicitly spiritual care, most provide considerable emotional support, and attention to patients' existential needs.

Finally, faith-based organizations such as churches, missions and clinics increasingly provide access to mental healthcare through the activities of the clergy [28], pastoral counseling staff, and mental health clinicians who may or may not work on site. Koenig [9] has described several levels of this integration: local religious congregations, networking and advocacy organizations, mission-driven faith-based services, and faith-integrated counseling services. Larger faith-based network and advocacy groups also provide social

services [9, pp. 161–172]. African-American churches in particular have become a venue for educating congregants about psychiatric conditions and reducing the stigma that continues to surround them in some religious circles. However, with the exception of a few programs such as Living Waters [35], faith based organizations offer co-ordinated rather than integrated care, directed more often at coping and recovery from symptoms than at synergizing deeper spiritual and emotional transformation.

2.2.10 FUTURE DIRECTIONS

As psychiatrists recognize the contributions to the mental health of their patients made by positive psychology, spiritual approaches such as AA, and integrative medicine, they are likely to become more open to consider the benefits of faith. As Christians in turn become less fearful of psychiatry, they are more likely to turn to secular mental health clinicians for help before they have become desperate, and disillusioned by their traditional spiritual sources of support. Such openness to positive experience between Christians and mental health professionals will be critical to realizing the opportunities suggested above for collaboration, and for consolidating them through teaching and research. Scholarship that takes place both outside the walls of Christian institutions will be increasingly important in drawing the attention of both secular psychiatrists and of Christians used to living within those walls.

In summary, while psychiatry and Christianity share insights, values and concerns about the human condition, they differ in ways of knowing, emphasis, approach and role. Confusion about these differences has historically made clinicians vulnerable to psychologizing spiritual experience, believers vulnerable to spiritualizing mental illness, and both vulnerable to mistrusting and misunderstanding where each other stands. Clarifying the natural boundaries between psychiatry and the Christian faith has made it increasingly possible for professionals and patients to move between them with integrity, respect and appreciation. Recently, it has also become more possible for them to collaborate at points in diagnosis, treatment and delivery of care where the contributions of both are vitally needed.

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