

Man—Dust with a Destiny

Monty Barker - Psychiatrist

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Scientism

My early training in the 1960s was marked by the recent discovery and development of the new tranquillisers and antidepressants which, added to electroconvulsive therapy, benefited—and continue to benefit—patients with severe mental illness, - however misused such treatments may sometimes be. There seemed to be a new breakthrough in 'scientific psychiatry' which could reduce all psychic suffering to genetic predisposition and abnormal brain physiology, for there was now a physical treatment which could 'cure'. Some of the most vigorous exponents of this approach wrote highly popular texts, such as Dr William Sargant's *Battle for the Mind*. In his book, Dr Sargant equated brain and mind, and all mental (including religious) experiences were reduced to physiological reactions. His physiology and psychology were severely criticised and rejected by many scientists, but his general equation of mental and spiritual experiences remained unassailed by the same scientific world.

My own training was in a school of psychiatry which professed rigorous exploration of all aspects of a patient's physical, mental and social development before assessment and treatment. But I was intrigued to discover that although careful histories were demanded on upbringing, sexual development, relationships and employment, the patient's goals in life and religious beliefs (or lack of them) rarely merited a mention; the failure of a doctor to elicit such information was never criticised. Even less attention was paid to the significance of such belief or lack of it in terms of how persons conducted their lives, unless the presenting symptoms and distress were expressed in specifically religious terminology.

As a trainee psychiatrist I became aware that most of my senior colleagues would seek only the clinical symptoms of their patients and ignore attitudes and value systems, viewing these as entirely personal matters not to be explored by the psychiatrist. A few would take a direct and usually hostile approach, tending automatically to blame strongly held religious views as being at least partly causal of a patient's illness. My interest in these matters provoked an invitation to review the subject of 'Religion and Psychiatry' at the weekly postgraduate meeting. By the mid-sixties, there had been only one major paper on the subject of religion and psychiatric illness in the fifty-year history of the leading British psychiatric journal; and that Paper seemed to have been included only because it was a special guest lecture traditionally published in the journal each year. My own thesis was that a truly scientific approach within psychiatry could occur only where the patient's beliefs and goals, religious or otherwise, were explored along with the whole life situation. Everyone lives in accordance with some belief, whether expressed in religious terms or not, and to neglect the significance of this within a patient's life reduces that person in some way and makes him or her less than human.

Thirty years on the materialist and determinist bias to the understanding of psychiatric illness still has its followers. In an academic meeting exploring various approaches to understanding and treating depressed patients, a leading academic psychiatrist recently declared that he preferred to see patients as 'biological organisms predisposed by their genetic inheritance and subjected to certain life events'. The organic factors and the events affecting a patient's life were looked upon as legitimate subjects for

study, but the person's own beliefs and the framework within which he understood and ordered life and events were looked upon as irrelevant.

It is an attitude dissected by Richard Holloway, now the Bishop of Edinburgh, when he wrote:

This is my dilemma... I am dust and ashes, frail and wayward, a set of predetermined behavioural responses, programmed by my genetic inheritance and by social context, riddled with fears, beset with needs whose origins I do not understand and whose satisfaction I cannot achieve, quintessence of dust, and unto dust I shall return. Who can expect much of that?

But he went on to say:

There is something else in me; there is an awareness that, truly, I am not what I am; and what I am and what I am not is what I truly am. Dust I may be, but troubled dust, dust that dreams, dust that has strange premonitions of transfiguration, of a glory in store, a destiny prepared, an inheritance that one day will be my own.

Relativism

These words reflect a change of emphasis that has taken place in the psychiatric profession. A new generation of psychiatrists, nurtured in the swinging sixties and influenced by a growing interest in 'consciousness', 'awareness' and 'spiritual' values, began to search for 'personal growth, character transformation, psychological rebirth and even mystical experience'. Physical methods of treating psychiatric illness and even the diagnostic categories of traditional psychiatry were severely criticised. By the 1970s there was a burgeoning of 'talking treatments', more technically known as psychotherapies and counselling programmes. Where Bishop Holloway had sought to direct his hearers to that longing for God the Creator innate in the hearts of all men, the new therapists offered fuller understanding and 'self-actualisation' through an ever-increasing number of psychotherapy programmes. One American writer spoke of the seventies as the 'me decade' because of the preoccupation with 'my needs' and 'let's talk about me' approaches.

All this undoubtedly indicated a deep spiritual hunger. It was illustrated by one of my colleagues who described his own pilgrimage from 'rational humanism' to 'devotional humanism', by which he meant a discovery of a need for meditation and personal values based upon what now would be called 'green issues'. Words such as 'fulfilment', 'wholeness' and 'integration', often described in almost spiritual terms, began to appear in psychiatric texts, although any attempt to see these as deriving from a religious or theistic context was met with a sharp rebuttal.

This development, coupled with pluralism with its many Philosophical positions and religious beliefs, has led to Psychiatrists becoming increasingly aware that they can no longer ignore the belief structures and the value systems of their patients. Their attitude became that either these are cultural variants and 'true' and valid for the individuals concerned but requiring no response from scientific psychiatry, or, as one leading psychiatrist expressed in a paper to the Royal Society of Health, 'There is a significant element in life and health to do with meaning, which is concerned with the direction of one's life . . . the psychiatrist should allow the patient to develop and express his own spiritual values. . . .' He went on to suggest that one of the functions of the psychiatrist may be 'helping the patient to find his god'.¹

The fact that antidepressants and other psychotropic medication have been so successful in treating the more severe psychiatric disorders has led to increasing attention being directed to lesser disorders. An example of this is the anxiety and depression which often occur in family relationships. In the 1950s, marital problems and their associated distress would have been dismissed by many psychiatrists as inappropriate referrals to a psychiatric clinic. By the 1970s, marital problems and marital therapy merited a whole section in a postgraduate text on 'Recent Advances in Psychiatry', where it was argued that it was 'better to encourage the breakup of a relationship which was unfulfilling for one or other party

where there was the possibility of forming a more fulfilling relationship subsequently'². This was in spite of the fact that the author acknowledged that there were no scientific or follow-up studies available to support his suggestion and that second marriages have a higher rate of breakdown than first ones. At the time, it was received wisdom that children would be happier to be removed from a situation where their parents were constantly bickering or in conflict. My own reflection was that children more often wished their parents to remain together, and, if forced to make such a choice, were influenced more by where security seemed to lie; where teddy bear was tended to be more influential than which parent to select. This was quite apart from the observation that every broken relationship makes it more difficult to believe in the permanence of any subsequent relationship. It was the pioneering and persistent work of a practising Christian, Dr Jack Dominion, who patiently conducted studies in his Family Research Unit in London, which confirmed the high degree of mental and physical illness arising out of divorce and family breakup, quite apart from the enormous cost to the nation economically.

These issues have rightly gained the attention of the press and have resulted in much closer scrutiny of the assumption that desires are the same as rights, and one's own fulfilment is good. A Times leader (21 May 1990) commented:

The 1960s consensus that quick and easy divorce was in the best interests of all parties is increasingly open to doubt. Experts now say that we have underestimated the damage done to children by divorce. Moreover a surprising number of people who get divorced then regret it. The problem seems to be that once an unhappy couple approach a lawyer they are driven to divorce as inexorably as the military mobilisations in the summer of 1914 led to war.

It has to be said that many psychiatrists and social scientists were not far behind the alleged activity of the lawyers in the pressure put upon individuals, even within a so-called therapeutic situation. Even if there was no attempt to impose values and beliefs upon patients or to bring emotional pressure to bear upon individuals in a time of great vulnerability, I often felt that there was less than honest dealing with such individuals when the specialists too readily accepted the value system of the patient under treatment.

The psalmist in Psalm 8:4 asked the question 'What man?', and the writer of Ecclesiastes debated with himself regarding the meaning of life. The lusty Roman poet Ovid, with no background of Jewish thought or contact, nevertheless echoed the words of St Paul in Romans 7 when he said, 'I see the better things and I agree with them, but I follow the worse.' Such questions are asked as often today as in former days; one leading psychiatrist identifies this as 'man is still searching for a map of man'. His own solution was that provided by traditional psychoanalysis. In this century the emergence of biological and behavioural sciences has produced several 'maps of man', from psycho analysis to behaviour modification, in an attempt to understand man and thereby to heal or resolve his tensions. One researcher on human sexuality summed up his conclusions after decades of study and research in the following words:

Paradoxically further study of the continually increasing volume of publications has led to less firm opinions than before. Increasing awareness of the complexities of the subject brings with it the realisation that on many issues it would be wise to suspend judgment pending further research. Indeed one conclusion that can be expressed without fear of contradiction is that much more needs to be learnt about human sexuality even before quite elementary questions can be answered with any degree of confidence.³

Experience suggests that further research could make him even less sure.

One of the prerequisites of the 'ideal psychiatrist' is 'the ability to be detached at times from any value judgment', able to be 'accepting and totally free of prejudice (an ability only found in those who genuinely possess very well defined values and have a personality that is mature)'.⁴ It is an error to believe that only those without well defined, and hopefully thought out values are tolerant and accepting. On the contrary, the absence of such values and beliefs may be dangerous.

Dualism

Harry Williams, writing of his experience as a psychiatric patient stated:

A psychiatrist should be chosen because he is a skilled psychiatrist and not because he is a good Catholic or reads the Bible every morning. I have a lasting suspicion of people who are known as a Christian dentist or a Christian doctor or a Christian psychiatrist or a Christian chiroprapist. Invariably it means that they are bad at their craft. God is honoured by a dentist being a good dentist, not by his singing hymns.⁵

He rightly points to the fear of psychiatrists in the minds of many Christians who protect themselves and their beliefs by insisting on a 'Christian psychiatrist'. I agree entirely with this and strongly believe that the prerequisite of a good psychiatrist is that he should be someone respected as a person of ability, integrity and of good standing among his colleagues, including non-psychiatrists. I do not believe that it necessarily helps for the worldview of the patient to be understood by the psychiatrist; what is important is the open acknowledgement and discussion of where worldviews differ and an acceptance by both psychiatrist and patient as to the limits upon such issues. Openness and honesty is often all that is necessary in order to establish a good therapeutic relationship between doctor and patient, even when worldviews and value systems are disparate.

However, the philosophical and antireligious bias of Freud, especially as portrayed by some of his followers, has led to the public perception of psychiatrists as generally being anti-God and hostile to Christian belief, even though Freud's views have not been a dominant influence upon the practice of psychiatry in this country. Few psychiatrists in Britain hold the rigid philosophical and reductionist views of men like Maudsley, Freud and Sargant, and they would be unhappy to stray far from such a position in their practice. This has had a generally beneficial result in ensuring a pragmatic approach to the severer forms of Psychiatric illness, ensuring treatment with proven and scientifically assessed methods of treatment.

The same has not been so true when psychiatrists have dealt with patients with lesser forms of psychiatric disorder, with some of the results mentioned previously. This has led to a fear of the practice of psychiatry in many Christian medical students and young doctors; although they are attracted to dealing with patients on a broader basis than purely the physical, they are unhappy with the reputed hostility of psychiatrists to religious faith. They are often confirmed in this view by senior doctors, not least those known for a Christian commitment but sceptical about the value of psychiatry, largely out of deficiencies in their own training. Such individuals often profess to be fearful for the continued spiritual wellbeing of any Christian who should enter into the practice of such a subject. I personally am grateful to the canny Scots physician who quietly encouraged me in my medical student days, on the ground that 'There is a need for Christians to practise psychiatry and demonstrate that it is possible to be truly scientific in one's thinking and at the same time committed to Christ'.

A small pamphlet which I wrote, called Starting Psychiatry, was published to help Christian medical students embarking on their psychiatric studies and experiencing difficulties with the special problems posed by the nature of the suffering of these patients and special language and approaches of psychiatry.⁶ It is a booklet which has remained in print for twenty years and has, I hope, contributed something to the changed attitudes which have resulted in many more Christian doctors being prepared to pursue a career in psychiatry than twenty years ago.

In it I focused upon the need for Christian and non-Christian alike to examine their attitudes, lest they be guilty of smuggling their own special prejudices and preconceptions into their practice of medicine. Such self-examination is not easy, as it means calling into question one's own beliefs, standards and objectives in life when faced with patients and colleagues who would hold very different views on life and may have quite deliberately and specifically rejected a Christian standpoint.

Unfortunately, there is still a strongly held view among both Christians and non-Christians that mental illness is something to be ashamed of, and that it is self-induced. The approach to the mentally ill adopted by such individuals is to search for some approach, often a panacea, along the lines that if only one's diet, exercise, lifestyle or some procedure is rigorously held to, then all mental disorder will disappear. In some Christian circles, conversion, or special healing procedures, or exorcism would be spiritual counterparts. These, of course, are no different from the 'nothing but' approaches so frequently encountered in the philosophical framework of the materialist and atheist, and are equally reductionist. The temptation to resort to quick solutions is always present. Anything which appears to offer solutions and cure is always more seductive and attractive than the preparedness to accept that in human behaviour and illness, resolution and relief is more usual. Inexperience and lack of familiarity with patients often leads the medical student and young psychiatrist to become impatient with a person who 'won't be cured', and to take a punitive approach to them. Among Christians there is the often-expressed belief that 'if only' a patient would become a Christian then all difficulties would disappear. In fact, quite the reverse may occur. Becoming a Christian may produce extra conflict in a person who finds himself at greater variance with his family and with colleagues as he faces challenges to an established lifestyle.

Often there is a dualism in Christian thinking which reduces everything in life to either the organic or the spiritual, and refuses to look at research which demonstrates that our experiences and mental processes are a complex interaction of the effects of our genetic background, family and upbringing, life events, and goals in life. Some Christians are reluctant to look at the very human issues behind their illness and instead demand 'spiritual remedies' from the Christian psychiatrist, having already exhausted their normal spiritual mentors. The plethora of 'how to overcome ...' books in secular bookshops have their parallel in Christian books supporting a thriving Christian alternative medicine, avidly backed by those keen to have a personalised medicine but not prepared to subject the claims of such 'Christian therapies' to proper evaluation.⁷

Conclusion

Psychiatrists are faced with many who have lived their life in such a way that pain, grief and depression have been the almost inevitable fruit of their conduct, and others who have had unfulfilled goals and objectives in their work and relationships. The psychiatrist has to explore the roots of his patient's behaviour, help him retrace his steps and find a new purpose for going forward in life. Whatever happens, no psychiatrist should force his own belief or faith upon a patient. Such an act would be a fundamental transgression of the professional nature of the doctor/patient relationship which can never be an equal relationship, and even less so where the patient's judgement may be impaired and vulnerability increased by psychiatric illness. Sadly, many Christians have felt that their problems have been blame entirely upon their Christian viewpoint, but it also has to be said that many Christian patients have refused to examine how little thought-through and reality-based their own faith has been. As a result, they have criticised unjustly their psychiatrist, be he non-Christian or Christian, for seeking to explore discrepancies in their own belief and behaviour.

Perhaps the reason why the medical profession has a significantly higher incidence of alcohol abuse and suicide than many professions derives from the fact that such issues are seldom raised in the training of medical students or postgraduates. Trying to deal with patients who have presented with deliberate self-harm, diseases incurred by abuse, in addition to those who have suffered from the malevolence of fate or even members of their own family, brings distress and even despair which cannot always be assuaged by more research, more precise definitions or increased devotion to one's work.

The theologian, J.I. Packer, has said, 'Man is a biologically developed, language-using, tool-making, social, economic, political animal with a complicated physiology and even more complicated psychology . . . and that is to say nothing about the historical and philosophical contributions to our understanding of man.' That does not mean that we ought to interpret biblical language as equivalent to any behavioural jargon in vogue; this would reduce ultimate truth to dependence on a limited culture-dependent understanding of man. It does not mean that we should read Freudian concepts into biblical terminology,

equating the ego with the soul and the superego with conscience. It does not mean that we should use biblical terminology and words as though Scripture had to include some allusion to every possible discovery of man, or that the Bible is a minitreatise in psychology or behavioural sciences. It does mean that we have to use the insights of all that science and research have made available in the realm of human experience and conflict, while remaining sceptical as to these being the last word.

As a psychiatrist I have to deal with the lives of men and women in illness, conflict and tension. But I myself need to be wrestling at the same time with the biblical revelation regarding the human condition and man's ultimate need. The first illumines the second, but the second gives the context within which the first is to be understood and explored. Here is the framework within which I approach my patients and assess the current practice of psychiatry, aware that there is no easy synthesis but an ongoing fight against a blinkered scientism on the one hand and an easy believism on the other. Even 'good doctors' can slip into either error.

At the end of the day, the psychiatrist who is a Christian knows the limitations of his work. He knows that new discoveries will be made about God's creation and about human behaviour. But he also believes that something new happened when God the Creator of all came to live among men in the Person of Jesus, that he died on a cross for us and rose again from the dead to bring new life to all who put their trust in him. This is at the heart of my life.

As a psychiatrist, I am tempted to agree with the writer of Ecclesiastes who said that there was nothing new on the face of the earth. Finding a meaning in life and a god who suits undoubtedly helps people, but it is possible to miss or refuse to meet the only God who is the basis of all life. I cannot give a meaning for life to be dispensed like pills and therapy; I can receive the confessions of wrongs and listen to the outpourings of guilt so that people feel better, but only Jesus Christ can forgive and remove guilt. As a psychiatrist I can encourage, challenge and direct people to act differently, but only the Spirit of God ultimately gives people new power to act as God wills; I can explore possibilities and ways of living a better and different life, but Jesus Christ is the only Person who has said, 'I am the way, the truth and the life, no one comes to the Father except through me' (Jn 14:6). These are strong words which draw their credibility from the life, teaching, death and resurrection of Jesus Christ, and it is to him that I seek to witness as a Christian.

Notes

- 1 A.C.P. Sims, 'The Psychiatrist as a Priest', *Hospital Update* (November 1988), p 2129.
- 2 S. Crown, *Recent Advances in Psychiatry* (Duckworth, 1971), p201.
- 3 D.J. West, *Homosexuality Re-examined* (Duckworth, 1977), p316.
- 4 K. Jaspers, *General Psychopathology* (Manchester University Press, 1963), pp 808-809.
- 5 H. Williams, *Someday I'll Find You* (Mitchell Beazley 1982) p 167.
- 6 M.G. Barker, *Starting Psychiatry* (CMF, 1971).
- 7 These are issues explored further in two papers by the author: 'Biblical and Psychological Methods of Pastoral Care' in Malcolm Jeeves (ed). *Behavioural Sciences: a Christian Perspective* (IVP, 1984), pp 230-245; 'Psychological Aspects of Inner Healing' in Nigel Cameron and Sinclair Ferguson (eds), *Pulpit and People* (Rutherford House: Edinburgh, 1986), pp 89-102.

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