

Virtual Mentor

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Clinical Case

The Evangelizing Patient

Commentaries by J. Wesley Boyd, MD, PhD, John Dunlop, MD, and
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Michael Washington is a 38-year-old electrician. He arrives at the office of Dr Richard Martin, his psychiatrist, after a recent hospitalization for his first episode of mania. He describes a history of several depressive episodes in the past (though he never sought treatment). He says he has never abused drugs and has had no psychotic episodes. Seven years ago, Mr Washington reports, he experienced a dramatic conversion. Before this conversion, he was a heavy gambler and often abused his wife and 2 children. "Ever since I got saved, I haven't gambled, and I've been trying to be good to my family," Mr Washington says. His wife, significantly less religious than he, agrees that the change was dramatic, but his heavy involvement with a local Pentecostal church since that time has been a source of tension in their marriage.

The manic episode occurred 3 weeks before, when Mr Washington gradually noticed himself feeling energetic, very optimistic, "like I could take on the world." He began several projects at home, working long into the night, "but I still felt great in the morning and had no problem going to work." He also describes praying long into the night, and, on more than 1 occasion, he believes he heard God telling him to follow certain courses of action. For example, he sensed God directing him to give a large sum of money to a single mother in his church, and, when his wife discovered the money missing from their bank account, she was alarmed and insisted he see a doctor—"You've gone way too far this time," she said.

He was hospitalized for several days and started on a regimen of a mood stabilizer and antipsychotic medication. During his third day in the hospital, one of the nurses heard him repeating unintelligible syllables for several hours. After discussion with his wife, Mr Washington was discharged with orders to follow up at a clinic.

At Dr Martin's office, Mr Washington appears significantly subdued. He makes good eye contact, and is candid and cooperative, not displaying any pressured speech or tangentiality. In attempting to assess Mr Washington's insight, Dr Martin asks, "So tell me, Mr Washington, what do you understand about why you were hospitalized?"

"You know, doctor, this is something I've been thinking and praying a lot about, and, to tell you the truth, I realize this might sound kind of weird, but I think God allowed me to get sick so that I could share the gospel with you. In talking with you, it doesn't sound like you know the Lord. I may be sick, but I've gotta tell you! Jesus has made all the difference in my life. He's made me happy and given me peace inside, and I

haven't wanted to gamble or hurt my wife or kids ever since I gave my life to Him. Tell me, Mr Washington, have you ever accepted Jesus as your Savior?"

Commentary 1

by J. Wesley Boyd, MD, PhD

Mr Washington's conversion brought about a dramatic change in his abusive behavior. Following in the pragmatic tradition of William James who said that the only good measure of the truth of any religious belief is whether or not its effects in the world are beneficial and healthy [1], I must support Mr Washington's religious beliefs regardless of their ontological status or whether I would embrace similar beliefs for myself.

I see Mr Washington's religious beliefs over the last 7 years as distinct from the manic episode that has recently led him to be hospitalized, though I certainly do not know what caused the manic episode. It may simply have been bad neurochemistry, a call from God, or something else.

The fact that the episode was replete with religious grandiosity and delusions is not surprising given the place religion occupies in his everyday life. In manic states, individuals often take their everyday concerns and issues and amplify them in some dramatic way. A musician in such a state, for example, might lock himself in his studio for days, producing little of worth but convinced he's making brilliant music that will instantly bring the music world to its knees.

Ethical Issues and Concerns

When patients agree with psychiatrists' recommendations for treatment, we rarely raise concerns about informed consent. The implicit thinking seems to be, "My patient is conforming to my recommendations and wishes, therefore he or she must be properly informed and thinking clearly." But, when a patient believes that God gave him an illness so that he might convert his psychiatrist to fundamentalist Christianity, we certainly ought to raise the issue of whether this patient understands his illness and, additionally, whether he has the ability to give informed consent about receiving treatment.

If pressed, I'd probably conclude that Mr Washington does *not* fully understand the nature of his illness and therefore is not able to give true informed consent about his treatment. Even so, his understanding of the nature of his illness probably is not too much different from that of many individuals because many people ascribe religious or supernatural meaning to their suffering (or their successes, for that matter). Many of my depressed patients, for example, see every ill that befalls them as deserved because they perceive of their own nature as inherently evil. Analogously, many manic patients see any good that comes their way (whether real or imagined) as something deserved because of how special and wonderful they are.

The fact, though, that Mr Washington's understanding of his illness jibes (to some extent) with that of the majority of humanity does not, of course, mean he is correct in

his understanding? recall that most of the world used to think the earth was flat and that slavery was acceptable? but it does put Mr Washington's beliefs into a broader context.

Although I question Mr Washington's ability to act autonomously and give meaningful informed consent, I do not see autonomy as an all or nothing proposition because, in theory, full autonomy would require *complete* knowledge, something none of us ever has. Instead, I see us as existing along a continuum between full autonomy and no autonomy whatsoever, with some of us closer to one end and some closer to the other.

Should I refuse to treat Mr Washington because he does not understand the nature of his illness and, moreover, is pushing his religion on me? Absolutely not! Patients are often pushy in all kinds of ways. Besides, psychiatric illness often if not always strikes at the core of one's being and in its insidious way often compromises one's ability to act reasonably and make informed decisions. Since this is the very nature of psychiatric illness, I would be forsaking my duty as a physician if I were to stop seeing Mr Washington and reject him as a patient based on these reasons.

Handling the Question about Religion

The final ethical concern I'll raise is one of maintaining proper boundaries with patients. What should we be willing to tell our patients about ourselves? Specifically, should I answer Mr Washington's question about my own religious belief? Besides, is my faith status even directly relevant to our work together?

It would be disingenuous of me to answer his inquiry with the standard psychiatric question, "Why are you asking?" because any remotely aware individual knows that evangelicals care a lot about the religious beliefs of those around them. More often than not our patients know far more about us than we might imagine. Whether due to our conversations with them, a Google search, or merely examining the art on our walls or the books on our shelves, patients often make highly accurate guesses about our religious or political beliefs as well as our dietary and exercise habits.

How I Would Proceed Clinically

Even though I would never take Mr Washington's religion for myself, I would strongly support his religious belief because it has kept him from abusing his wife and away from the bottle. That same religion has him convinced he has an illness (many psychiatric patients want to deny any illness) and will probably keep him coming to appointments and taking his medication. The pragmatic utilitarian in me thus supports his belief system.

At some point I would probably tell Mr Washington that I doubt he'd ever convert me, even though I don't think that would deter him in his mission. And that would be just fine with me, because I assume that his ongoing hope of converting me would be one of the reasons he might continue our relationship.

In some sense, Mr Washington and I would both be using one another for our own ends. I'd be looking to keep him healthy and, in the process, feel good about my own psychiatric abilities, and Mr Washington would be looking to convert me. This view might appear a bit cynical, but as long as we are both fairly honest about our intentions, our interactions with one another will be both more above board and more respectful than most relationships, professional or personal.

Reference

1. James W. *The Varieties of Religious Experience*. New York, NY: New American Library; 1958:308.

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Commentary 2

by John Dunlop, MD

Dr Martin has no control over Mr Washington's initiation of a conversation about faith. Thus the ethical question we must address has to do with Dr Martin's response? with the appropriateness of allowing this patient to share his faith with his therapist. Simply put, "Is there room for religious discussion within the practice of medicine?"

Responding to Patients Who Share Their Faith

Dr Martin could ethically choose between several options:

1. He could say, "Mr Washington, you need to understand that I am a psychiatry professional. I am happy to treat your mental health, but I will not get involved in your religion."
2. He could say, "Mr Washington, I recognize that your faith is very important to you and that it has been of significant help to you. You should understand that I, too, have my own faith (or I am not a man of faith) and just as I am not trying to change your faith, I would request that you not try to influence mine. I see the value of your faith to you and would encourage you to continue to practice it."
3. Alternatively, "Thank you. I suspect I am not personally interested in your faith, but it would help me understand you better and therefore better care for you if you did take a few minutes to explain your faith to me."
4. Finally, "Thank you. I, too, have been on a personal search for further meaning in life and I would be interested in hearing about your beliefs. It is not appropriate, however, for that to be part of our professional relationship, especially when your insurance company is paying for our time together. I would prefer to talk to your pastor to learn more about your beliefs."

Some preliminary observations are foundational to this physician's choice.

- Any response must be grounded in truth. Dr Martin must be honest and straightforward in his response. He must not feign interest in Mr Washington's faith in a way designed to manipulate. If he has no interest he must refuse to pursue the discussion. If he feels that Mr Washington's church involvement is harmful to his planned treatment program, he must candidly state that. Mr Washington may find that grounds to request a transfer of care and, in that case, Dr Martin must comply.
- A treatment plan will, when possible, utilize many of the people and institutions influential in the patient's life. Dr Martin should recognize that, after his conversion experience, Mr Washington's life has significantly improved. It has not all been positive, however, inasmuch as it was through the church that the present exacerbation occurred.

It would appear likely that no matter how Dr Martin responds to Mr Washington's request, Mr Washington will continue to be involved in the church. It would seem advantageous therefore to consider how to make Mr Washington's church involvement be positive. Many churches employ counselors or have members of the pastoral staff trained in counseling. Dr Martin may find them a useful adjunct within his therapeutic plan. Other churches foster "men's accountability relationships" for people with a variety of behavioral or social problems.

It also seems clear that there is growing tension between Mr Washington's church and his wife. These are apparently the major influences in his life, and, for both of them to continue to have optimal beneficial effect, this tension must be dealt with. Dr Martin should try to help Mr Washington recognize that, though his wife does not share his faith, she can be a reality check for him.

- It is increasingly difficult to distinguish between matters of body (neurochemistry), soul (the traditional domain of the psychiatric analyst), and spirit (matters of faith). Multiple studies show a genetic or biochemical basis for an interest in religion (the religion gene). Recently Koenig et al have published a twin study demonstrating a genetic influence on religious choices [1]. Do those studies contradict the validity of religious experience? No more so than would the certainty that one is genetically equipped to excel in math exclude someone as a Nobel laureate for discoveries made. Mr Washington's biochemical imbalance may have predisposed him toward religion, but that should have no bearing on the validity of his experience with his religion. An area like this of genetic predisposition may be viewed as an asset in constructing a therapeutic plan for any patient. Without question, genetic predispositions can also lead to destructive involvements, and that is where discernment is needed.

If Dr Martin is sincerely interested in pursuing Mr Washington's faith for his own sake, he must be careful not to do this "on company time." He would

also be well advised to speak to someone other than his patient about this to avoid any conflict of interest within their professional relationship.

Recommendations

Dr Martin must decide whether, in his professional judgment, Mr Washington's church involvement offers more positives than negatives. If he feels that it is essentially harmful for Mr Washington, he must candidly say so and indicate that he will not be supportive. If Dr Martin is open to the possibility that Mr Washington's church involvement is helpful to him, he may choose then to find out more about the church and be able to work within the church structure to help Mr Washington. Dr Martin should also try to smooth out the relationship between Mrs Washington, Mr Washington, and the church. If Dr Martin has a sincere interest in Mr Washington's faith, he needs to pursue that outside of business hours.

Reference

1. Koenig LB, McGue M, Krueger RF, Bouchard TJ. Genetic and environmental influences on religiousness: findings for retrospective and current religiousness ratings. *J Pers.* 2005;73:471-488.

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Commentary 3

by Harold Koenig, MD, MHSc

Mr Washington does appear to have had a manic episode, but his symptoms do not sound all that severe when one considers his religious background. Mr Washington had experienced elevated mood, increased energy, and decreased need for sleep. He made some rather poor decisions? particularly with regard to giving a large sum of money without first conferring with his wife. Nevertheless, many of his symptoms or implied pathology may have been a direct result of his religious beliefs.

Giving to the poor and needy is certainly consistent with his religious teachings and is not that bizarre. Had there been no conflict with his wife about this, and depending on his financial situation, such a decision could have been quite reasonable, especially if his wife had been as religious as he. Similarly, hearing God's voice telling him to do things could easily be consistent with his Pentecostal beliefs, as could the glossolalia or "speaking in tongues," which accounts for the unintelligible nonsense syllables overheard by the nurse. Moreover, hearing God's voice is something that is actively encouraged in fundamentalist Christian circles. This is also true concerning his explanation for needing hospitalization, expressed during the follow-up visit with his doctor, and his attempt to evangelize his psychiatrist. Many Pentecostals would explain such an episode this way, reasoning that this was part of God's plan and that God allowed this so that some good might result—an explanation that indeed may help the patient psychologically integrate and cope with the illness.

In fact, this person may not have come to the attention of health care professionals at all had it not been for the conflict between his and his wife's religious beliefs. There is

no doubt that the patient has mania, but there are certainly manic people on the streets who never come to the attention of mental health professionals, particularly if their cycles and symptoms are not severe and if they haven't bothered family members or come into conflict with the law. In this case, neither the patient nor his church community would probably have brought him in for treatment. Without treatment, he may have cycled back to normal or into a mild depression (especially since there is no history of severe mania or depression).

I believe that the patient needed treatment. It sounds, though, like he was cooperative about it and in fact improved after only a few days. This is unlike many of the manic patients whom I have encountered in practice, whom we all know can be extremely resistant and combative, with bizarre delusions and hallucinations, and who may take several weeks to come under full control. Thus, my sense is that this was a mild case of mania that was largely expressed in terms of the patient's religious tradition.

The challenge here will be to make sure Mr Washington is taking his medication. The medication no doubt will have unpleasant side effects, interfere with his functioning, perhaps prevent euphoric religious experiences, and may be expensive for him. Since the patient does not acknowledge that he has a mental illness, he may not comply with treatment. Some rational therapists might even argue against the need for treatment, or at least against the need for as aggressive a treatment plan as might be pursued for someone with an agitated psychotic mania or severe episodes of suicidal depression (neither of which this patient has). Both doctor and patient must come to some agreement on what is and what is not pathological, and until there is common ground here, treatment will not go well.

What is considered "acceptable irrationality"? That may depend on what part of the world one is in, and in what period of history. In non-Western cultures, both now and especially in the past, societies have been much more accepting of irrational behavior than we are in the United States today. Many of these cultures normalized aberrant behavior, and the mentally ill in some societies were highly respected and valued (eg, considered to be shamans or spiritual guides) for their ability to "see" into the spiritual world that others could not. This may have enabled such persons to function better because these views preserved their self-esteem and often increased their social support. This approach to the mentally ill likely conferred benefits that such persons in our society do not have. Instead, we label such persons as crazy, often isolate them in institutions, and then treat them with powerful drugs that have disabling side effects that interfere with their functioning and quality of life.

How does a physician address a patient who reports that he or she has insight or communicates with the supernatural? It is essential that the physician determine if the symptom is truly psychotic or part of the religious or cultural beliefs of the patient's subculture. Carefully observing the patient, evaluating him or her over time and gathering information from family members is essential. In addition, however, information may need to be obtained from the patient's pastor or other members of his church, after requesting permission from the patient. If someone is psychotic or mentally ill, usually persons familiar with that patient's culture can readily tell. Friends

and associates may have noticed a change in the person's behavior, subtle excesses or insensitivities not consistent with usual behavior, and knowing the person over time would enable them to make judgments that a psychiatrist could simply not make unless he or she were familiar with the culture or social group and had seen the patient more than once or twice.

Where does religious belief begin and mental illness end? That may be difficult to determine, as Mr Washington's case illustrates. Until the mental health professional has become thoroughly familiar with the religious beliefs and culture of the patient, such determinations are often not possible without collateral information. Even that collateral information, especially if coming from family members with their own agendas and conflicts with the patient, needs to be further confirmed by gathering information from persons in the patient's religious or social community. And, as noted above, where religious belief ends and mental illness begins is likely determined by how each is defined within a given culture.

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