Many Will Come in My Name: Spiritual Care for Persons with a Delusion of Grandiosity with Religious Content

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I was having morning coffee on the maximum-security ward of the Forensic Psychiatric Hospital as I normally do, in order to meet patients and engage them in friendly conversation. I noticed a patient I did not recognize looking directly at me as he walked quickly toward me. He had a crew cut, a stocky build, and was well groomed, indicating he was not off the street. When he reached me, he extended his hand with a smile, saying, "Let me cut to the chase: I think I am Jesus Christ." Though he was not the first person I had met in my ministry as a psychiatric chaplain who identified as divine, Tom's strong conviction about this identity made a lasting impression on me.[1]

I followed Tom through his hospitalization and his reintegration into society. He phoned me one day and asked to meet for coffee. At one point in the conversation, he said, "Why aren't they phoning me?"

I looked at him, puzzled. "Who isn't phoning you?"

"You know, world leaders. They know who I am. Why aren't they phoning me and asking me to solve the problems they face?" Clearly, his belief about his divine identity persisted.

A few years later I opened the newspaper to read about a man reported missing and presumed drowned. His car was found by a bridge. It was registered in Tom's name.

Tom's story is one I have encountered in my role as chaplain at the provincial facility for persons living with a mental health issue who are

1. Patient names in this article are pseudonymous.

in conflict with the law. These persons are legally termed "not criminally responsible due to a mental disorder" (NCRMD). Tom had been arrested for a criminal action directly motivated by his delusion that he was Jesus Christ. He was brought to the hospital for an assessment. The doctor was not particularly interested in the *content* of Tom's delusion (i.e., that he thought he was Jesus); the doctor's role was to determine if Tom was mentally ill at the time of his offense.

But what is the chaplain's role? Should a chaplain be interested in the fact that Tom believes he is Jesus Christ? Or does the chaplain, like the doctor, have a different role to play? Patients like Tom may turn to religion and spirituality for help in coping with stress and losses due to their illness or with their hospitalization. In this institutional setting, chaplains are the face of religion and spirituality, and they need to hone their skills in order to provide healthy spiritual care to persons, like Tom, living with a grandiose religious delusion.

A study of this type of delusion provides an excellent opportunity to explore the interface between science and religion, between psychotic behavior and authentic religious experience. In this article, I wish to highlight the chaplain's role in spiritual care provision for those experiencing mental illness and to offer some recommendations for best practice within this context. I begin with an extended discussion of the clinical definition of a delusion. Next, I explore the sources of religious delusion. Finally, I apply theory to practice by analyzing a case study. This analysis illustrates the impact of a religious delusion on a person's life and helps clarify the unique role chaplains may play in providing pastoral and professional support to both the patient and clinical team. My hope is that this study will provide chaplains and others in positions of pastoral care knowledge and skills to both affirm patients' authentic spirituality and assist them to better manage their illness.

Delusion, Dimensions, and the DSM

At its most basic level, a delusion is simply a false belief. In clinical literature, a delusion is classified by its content or themes: erotomanic, persecutory, grandiose, jealous, somatic, and referential. In the grandiose type, persons believe they possess special powers or abilities. The grandiose theme often becomes religious, leading a person to believe they are Jesus Christ or some messenger from God. Religious delusions are not uncommon. One study reported religious delusions in 24 percent of patients

hospitalized with schizophrenia.[2] Recently, in my own facility on a ward of twenty-six patients, five thought themselves divine.

Delusions are symptoms of an illness. They occur most frequently in schizophrenia and bipolar disorder, often when the person is experiencing psychosis. They are "fixed," meaning that the content of delusions is unlikely to change, though the occurrence and intensity of delusions may lessen through the use of medications that address the underlying illness. Most troubling of all, clinicians know that persons experiencing delusions are at greater risk of harming or even killing themselves or someone else.

The *Diagnostic and Statistical Manual IV* (DSM IV) defines a delusion as "a false personal belief based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary."[3] The definition goes on to exempt beliefs "ordinarily accepted by other members of the person's culture or subculture." So, a delusional belief is one that is (1) false, (2) held with subjective certainty, (3) incorrigible, and (4) not an article of religious faith commonly held by a wider religious group.

The DSM's definition was adequate for clinicians to assess their patients, offering some criteria by which they could observe patients and make clinical judgments. If their patient was perhaps eccentric and hard to assess accurately, they had an exception clause that would recognize that religious groups often held beliefs that were not rational—such as the virgin birth or resurrection of Jesus—but held as tenets of the faith. However, as psychiatrist Joseph M. Pierre argues, the DSM is inadequate on this point in that diagnosis still relies on the subjective judgment of the clinician. For example, a clinician who is an atheist may assess as delusional any religious talk he or she judges irrational.[4] Clinicians therefore needed more precise criteria for diagnosing a person's religious beliefs as normal (at least culturally) or delusional (requiring medical treatment) than could be found in the *content* of the delusion, "I am Jesus Christ."

So researchers began to review the existing definition and to critique it on several points. First, it was noted that the falsity criterion was unsustainable because religious beliefs had no empirical evidence to test

2. Felicity Ng, "The Interface between Religion and Psychosis," *Australasian Psychiatry*, vol. 15, no. 1 (Feb 2007): 63.

3. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*, 4th edition (Washington, D.C.: American Psychiatric Association, 1994), 765.

4. Joseph Pierre, "Faith or Delusions? At the Crossroads of Religion and Psychosis," *Journal of Psychiatric Practice* (May 2001): 166.

for scientific validity. It might appear to be false, but this could not be proven. Second, it was pointed out that the beliefs in question were frequently held by many parts of the population not regarded as mentally ill. The television program *X Files*, for example, drew its audience from all ages and genders; many of Agent Mulder's fans agree, in the face of far-fetched paranormal claims, "the truth is out there."

This led researchers to investigate different and distinct *dimensions* of the delusion that could be measured. These dimensions were less concerned with the *content* of the delusion than they were concerned with the *experiential impact* the delusion had on the person's life. These dimensions included:

1. Conviction: the strength of the belief;
2. Preoccupation: the frequency of the delusion in a person's thoughts;
3. Emotional distress: the negative impact on a person;
4. The degree to which the delusion influenced one's action: what it causes a person to do.

For example, if we ask how a person behaved while confessing Christ as "conceived by the Holy Spirit, born of the Virgin Mary," we would probably conclude that no discernible impact accompanied the confession either in emotion or action. However, if that person asked to speak in the church about the virgin birth and began to get angry about why this was not a centerpiece in the church's theology, we might become concerned.

Research has provided empirical support for the use of dimensions in diagnosing a delusional belief. British psychologist Emmanuelle Peters developed a twenty-one-question inventory called the Peters Delusions Inventory (PDI) to test whether deluded persons (hospitalized with an active psychosis) answered differently than healthy persons on questions pertaining to their spiritual beliefs.[5] The PDI asked questions such as, "Do you ever feel as if you have been chosen by God in some way?" Or, "Do you ever feel that you are especially close to God?" The results of Peters's study revealed that both healthy and deluded persons shared uncommon beliefs; what differed was *how they experienced* those beliefs. For example, comparable numbers of healthy and deluded individuals responded affirmatively to the question, "Do you ever feel as if some people are not

5. Emmanuelle Peters, Stephen Joseph, Samantha Day, and Philippa Garety, "Measuring Delusional Ideation: The 21-Item Peters et al. Delusions Inventory (PDI)," *Schizophrenia Bulletin*, vol. 30, no. 4 (2004): 1013.

what they seem to be?" However, this belief caused deluded patients far greater distress, and they spent much more time thinking about it. As Peters concludes, "whether or not one becomes overtly deluded is determined not just by the content of mental events but also by the extent to which they are believed, how much they interfere with one's life, and their emotional impact."[6]

Most people do not experience beliefs as intensely or with as much distress as delusional persons. It is this intensity of experience that can cause an individual suffering from a mental illness to act on the delusion in pathological ways. While chaplains do not assess patients using the PDI, the dimensions it outlines nevertheless provide a useful guide for learning to recognize the behaviors of clinically delusional persons. With this understanding of how delusions are defined, we can now consider the origins of grandiose religious delusions.

The Roots of a Delusion: Biology, Culture, and Anomalous Experiences

While in a treatment planning meeting at the hospital, the psychiatrist asked if I had anything to contribute. "Yes. Mr. Johnson told me that he has been called by God to reinstate full sacrificial worship in the Jerusalem Temple." Thinking I had stumbled across a great discovery, I was surprised when the doctor, without looking up from the notes he was taking, simply said, "Yes, that is Mr. Johnson's *idiosyncratic belief*." Throughout the literature, the term "idiosyncratic belief" denotes an individual patient's delusional content. One patient, for example, told me, "I have been shot through the head three times and resurrected three times. Tell me I'm not better than Jesus Christ, who only resurrected once!" This was his idiosyncratic belief, the unique content of his delusion.

Researchers are trying to determine where patients get their delusional material and why they include what they do. Because delusions are generally fixed and difficult to alter, clinicians are less concerned about the content of the delusion, unless it is threatening, than with finding an effective medication to lessen the frequency or impact of the delusion. However, the chaplain will find it helpful to understand the source of the delusion in order to effectively support the patient. Three sources are usually given: biology, culture, and anomalous beliefs.

Biology. Every person, from infancy onward, is learning how to receive and interpret data from the external world in a way that seems

6. Ibid.

to be "right." The interpretation helps us navigate our relationships and environment. When the brain's activity is disrupted, this interpretation becomes distorted and our lives can become unmanageable. This distortion is the experience of psychosis. Felicity Ng defines psychosis as "a neuropathological disorder involving aberrant reception and/or processing of information."[7] An example of psychosis, or aberrant processing, was described to me by a patient who had studied his Social Insurance Number, comprised of three groups of three digits each. The sum of the first group was his daughter's age; the sum of the second, his son's age. This was proof, he claimed, that the third group of digits, 777, confirmed his identity as Jesus Christ, seven being the number of perfection. At that time, all number combinations held significance for him. Now, under medication that lessens his delusional thinking, he describes this significance as "illogical logic."

Ng explores some theories regarding delusions and brain pathology, citing a study by Saver and Rabin that suggests religious experience can arise from pathological brain processes.[8] In particular, they observe the well-documented association of epilepsy and religious experience: a number of religious experiences occur throughout and after epileptic seizures. They note that persons like St. Paul and Joan of Arc, among others, are suggested to have had symptoms consistent with epilepsy. The question is, did St. Paul have authentic religious encounters with God, or did he experience epileptic seizures? This question—and any question trying to establish the authenticity of religious experience—is beyond the scope of science.

Ng states that researchers have tentatively identified the limbic system, which is responsible for emotion, as the part of the brain responsible for religious experiences.[9] Again, this research raises the question, does this part of the brain create the *experience* of spiritual encounter, or is it interpreting an external experience that is authentically spiritual? Ng's research offers a thoughtful answer to this theological and scientific question. Religion, she notes, is a common human theme, possibly due to its intrinsic and cultural significance to humans and our natural propensity

7. Ng, "The Interface between Religion and Psychosis," 65.

8. Jeffrey L. Saver and John Rabin, "The Neural Substrates of Religious Experience," *Journal of Neuropsychiatry and Clinical Neurosciences*, vol. 9, no. 3 (1997): 498–501. For further analysis of Saver and Rabin's hypothesis see Ng, "The Interface between Religion and Psychosis," 64.

9. Ng, "The Interface between Religion and Psychosis," 64–65.

to interpret intense or discrepant perceptual events as spiritual or paranormal.[10] At the same time, there is evidence that points to brain dysfunction (specifically temporolimbic) in the biological origins of psychosis, which may be responsible for generating the type of perceptual experiences that resemble paranormal or spiritual events. Some conclude that religious experience is therefore nothing more than brain dysfunction. Ng opposes this application, respectfully distinguishing between the essence of religious beliefs—and their validity—and the research that, among other theories, suggests that the brain can mimic religious experiences: "the challenge lies in differentiating between religious culture and pathology, and this requires a thorough assessment of the dimensions of beliefs as well as minimizing premature judgment based on ignorance of unfamiliar religions."[11] A clinical review of psychosis and religious delusions does not challenge the basic value of religious faith. Rather, it offers an opportunity to consider possible roots of delusion. The clinician—and chaplain—will need to be cognizant of these roots when working with a patient experiencing such delusions.

Culture. Culture is the medium that gives us a framework through which to look at the world and answer questions of meaning such as: Why am I here? Who am I? Pierre writes that, "Beliefs and explanations, both delusional and religious, are culled from a cultural construction of reality. The myriad of world religions in different cultures is testament to this fact. Delusions too are drawn from the language and concepts of culture."[12] Whether a person is a member of an organized religion or simply lives in a culturally religious neighborhood or nation, this culture shapes and impacts that person.

Psychiatrist Robert Clark surveyed the delusional content of five Jewish patients in a private psychiatric hospital in Philadelphia.[13] He found that some of their delusions were consistent with themes in Jewish Scripture, but others included elements from the New Testament, perhaps through the influence of a dominant culture. Clark's study was intended to demonstrate that delusionary experiences cross cultural boundaries, sometimes in surprising ways. One of his patients, for example, imagined himself with incredible knowledge that he had gained from reading Genesis 1–3.

10. Ibid., 64.
11. Ibid., 65.
12. Pierre, "Faith or Delusions?" 169.
13. Robert A. Clarke, "Religious Delusions Among Jews," *American Journal of Psychotherapy*, vol. 34, no. 1 (1980): 62–71.

His delusion was congruent with his Jewish faith and culture. Another Jewish man, however, thought he was Jesus the Messiah. He experienced tingling in his palms, a symptom he believed came from the nails in the crucifixion. This notion, which would be intolerable for many Jews, stayed with him. Delusional content can be both culturally consistent and idiosyncratic!

Kausar Suhail and Shabnam Gauri[14] studied the delusional content of Pakistani Muslims diagnosed with schizophrenia. They found that highly religious persons had grandiose delusions, self-identifying as powerful figures contextual to Islamic Pakistan: God, Wali (pious person), the Prophet Mohammad, or a king. In addition to grandiose identities, highly religious patients also professed grandiose abilities, such as the ability to control physical elements such as lightening, wind, rain, and Jinn.[15] Addressing the universality of religious delusions, A.D. Gaines writes:

> Specific beliefs may be standardized culturally regardless of how bizarre they appear to the uninitiated. . . . E.g., certain beliefs, such as being controlled by a dead person, are clearly and without a doubt delusional. In fact, this is a common belief among the world's cultures. . . . Matters become complicated for clinicians where there are many constructions of reality of how the world works and why things happen.[16]

Needless to say, a Western trained psychiatrist or chaplain would be hard pressed to know whether a patient's claim to be Wali indicated delusion or piety. In today's increasingly secular and shrinking world, chaplains need to understand the cultural and religious context from which a patient comes. This understanding will assist them both to support the patient and to provide important feedback for the treatment team with regard to accepted religious norms. Ng affirms this when she argues that clinicians need to "recognize their own limitations in theological knowledge," encouraging them to seek "education of unfamiliar religious beliefs."[17]

Anomalous Experiences. A final source of delusions is the anoma-

14. Kausar Suhail and Shabnam Gauri, "Phenomenology of Delusions and Hallucinations in Schizophrenia by Religious Convictions," *Mental Health, Religion & Culture*, vol. 13, no. 3 (2010): 245–59.

15. Ibid., 254. Jinn are supernatural creatures in Islamic mythology, capable of good or evil. They can act upon or be acted upon by humans.

16. A. D. Gaines, "Culture-Specific Delusions: Sense and Nonsense in Cultural Context," *Psychiatric Clinics of North America*, vol. 18, no. 2 (1995): 281–301.

17. Ng, "The Interface between Religion and Psychosis," 65.

lous experience. Anomalous experiences are events that the recipient perceives as paranormal, psychic, or bizarre. Such an experience cannot be explained using the conventional laws of science, and therefore the person who experiences it may explain it as a divine encounter. For example, a climber ascends a mountain and reaches the top when suddenly the clouds part to reveal the brilliance of the sun. The climber is suddenly aware of an awesome presence and exclaims, "God must be here!" Spiritually healthy persons may understand anomalous experiences as God's providential intervention.[18] But such occurrences may give the vulnerable person delusional content as they try "to make sense of discrepant perceptual events."[19]

While all psychotic experiences are processed in the brain, Ng reminds us that their explanation is likely to be as complex as our neural pathways. For this reason, any explanation of origin will need to consider culture, biology, and anomalous experiences. The origin of a delusion falls under the domain of the clinician and is not essential knowledge for the chaplain. Nevertheless, as part of a multidisciplinary care team that brings both science and religion to the table, the chaplain's role is neither to defend the validity of religious beliefs nor simply dismiss them as unhealthy, but to support the patient and perhaps clinicians by modeling the positive role that religious faith can play, even if delusionary beliefs are present.

Healthy Spiritual Care: The Chaplain's Response

Let me review the basic understanding of a grandiose delusion with religious content. It is (1) a false belief, (2) symptomatic of a diagnosis like schizophrenia or bipolar disorder, often in the psychotic phase, and (3) "fixed," usually lessened through medication. Up to this point, I have been using medical and academic language. But as I noted, a delusion is symptomatic of something greater—the very life of the person suffering from the delusion. The words of Australian psychiatrists Nicholas Keks and Russell D'Souza should alert the chaplain to the challenge this person brings to spiritual care: "Psychoses exact a terrible toll on people. In approximately half the patients there is an enduring loss of richness of personality—the so-called deficit syndrome. Many people with psychoses

18. See Mark 1:10–11 for an anomalous experience at Jesus's baptism. The heavens are "ripped open" and God "speaks to him." But for reaction to Jesus's early ministry, see Mark 3:21: "And when his family heard it, they went out to seize him, for they were saying, 'He is out of his mind.'"

19. Ng, "The Interface between Religion and Psychosis," 64.

attempt and complete suicide."[20] It may be confusing to hear a person say, "They don't understand that I am Jesus Christ, and I will punish them for putting me in here," and then have conversation continue as though nothing unusual was said. For the chaplain, however, questions arise: How do I respond to this patient? How can I offer healthy spiritual care?

I offer here two basic practices a chaplain can use to work with such a patient. First, recognize the humanity of each patient and work to de-stigmatize the effects of the delusional beliefs. Second, make a spiritual assessment of the person in order to better understand what role religious faith or practice has played in the person's life. I will model the application of these practices by analyzing a patient case history. These practices provide a reality-based framework for chaplains to use when offering care to an individual with a religious delusion, both in and out of the hospital.

Humanization and De-stigmatization. When Tom came to me on the ward and announced, "I am Jesus Christ," I responded, "Do you have any other handles?" He provided his name. Reflecting on that exchange, I realized that without thinking I had done what chaplains are called to do: recognize the humanity of the person in front of them. Shaking his hand and learning his name were simple gestures to assure Tom that he was recognized as a person first and foremost, and to remind myself that, whatever else it may mean for Tom to "be Jesus Christ," it means he is human.

In his book, *Resurrecting the Person*,[21] John Swinton addresses the stigmatization persons living with a severe mental illness face. When people heard Tom call himself Jesus Christ, their attitudes toward him changed. His friends were no longer available; a romantic date became an impossibility. The stigmatization continued in the hospital after Tom was arrested. Legal and medical terminology are an inevitable part of each person's new identity when they have been arrested. Legally, they become a "remanded patient." Medically, they may be diagnosed as "a schizophrenic." Desiring to be accepted as a professional member of the medical team, chaplains may soon speak this language as well. Janet Foggie addresses this issue clearly and personally in her role as a mental health chaplain. She urges chaplains to resist the temptation of power

20. Nicholas Keks and Russell D'Souza, "Spirituality and Psychosis," *Australasian Psychiatry*, vol. 11, no. 2 (2003): 170.

21. John Swinton, *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems* (Nashville: Abingdon, 2000).

by instead taking the side of the patient:

> In my own working life and practice I have come to the conclusion that in order to work with a patient's religious delusions I have to lose my professional identity as one of *them*, the skeptical team, and become one of *us*, the patient belief group. I also have to prove my worth to the patient, allowing them to give me their view and not to contradict it immediately, to listen and ask questions that constantly reminded the patient that it is OK, indeed normal, to have a religious faith.[22]

For the chaplain, the importance of coming alongside a patient is particularly important when the patient begins to recover. Any spiritual thoughts or behavior will be suspect and may easily be labeled "schizophrenic." Chaplains must learn how to affirm authentic spirituality while recognizing some thoughts and experiences as psychotic fragments. A patient once said to me, "God is not pleased with me. I heard the shutters rattling, and that means he is not happy with my behavior." I replied, "I don't doubt that God speaks to you and is concerned about your behavior. I think that the rattling shutters might be your schizophrenia talking, though." He smiled and accepted my comment.

Assessment. One of the best tools a chaplain can use is a spiritual assessment. There is a growing body of literature that recognizes the importance of assessing a patient for their spiritual beliefs and practices.[23] The HOPE Assessment tool[24] was designed by two medical doctors for use in their daily practice, using the word "hope" as an acrostic checklist:

> H: sources of hope, strength, comfort, meaning, peace, love, and connection
> O: the role of organized religion in the patient's faith
> P: personal spirituality and practices
> E: effects of religious beliefs on medical care and end-of-life decisions

22. Janet Foggie, "Orthodoxy or Heresy? A New Way of Looking at Spiritual Care for People with Delusional Beliefs," *Scottish Journal of Healthcare Chaplaincy*, vol. 10, no. 1 (2007): 25.

23. See, for example, George Fitchett, *Assessing Spiritual Need: A Guide for Caregivers* (Minneapolis: Augsburg/Fortress, 1993).

24. Gowri Anandarajah and Ellen Hight, "Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment," *American Family Physician*, vol. 63, no. 1 (2001): 81–89.

Using these categories, the assessor simply asks the patient: What are your sources of hope? What is the role of organized religion in your faith? And so on. Administering a spiritual assessment is a learned skill. One needs to be familiar with the questions in order to probe for more nuanced answers. These questions equip the chaplain with doorways for conversation and are useful in discerning and encouraging healthy spirituality in patients.

Practice. Case studies are used to illustrate the nature of the patient's illness and the clinician's treatment of that patient. In order to offer an extended example of this practice, I offer here my reflections on a case study provided by Keks and D'Souza.[25] I have divided the case study into four sections, following each with my commentary, drawing from my clinical and pastoral experience to demonstrate both the impact the delusion has on the person and what healthy spiritual care may look like. I begin with the title given by Keks and D'Souza:

"Case 2: The Anti-abortion Campaigner"

This title unwittingly stigmatizes Bill by connecting his mentally ill behavior with an unpopular moral issue. Bill's religious background is Roman Catholic—a tradition that is unabashedly pro-life, in which it is not uncommon to demonstrate publicly at women's health clinics. Since Bill's campaigning occurs during his elevated (manic) moods, the moniker might seem to be appropriate, at least in the doctor's mind. But why identify Bill in this way? When his mood regulates, the campaigning stops. Then what is he? As I wrote earlier, recognizing the humanity of a person with mental illness and avoiding stigmatization is an important challenge for the chaplain.

> A 44-year-old single, unemployed man was living alone. . . . He had an 18-year history of schizoaffective disorder with no hospitalizations for some time, but continued to experience marked mood fluctuations and chronic underlying psychosis with persecutory delusional themes.[26]

This first paragraph gives us a snapshot of Bill's medical history and current situation. We learn that his diagnosis is schizoaffective. As the chaplain, I would need to understand what this diagnosis means. Schizo-

25. Keks and D'Souza, "Spirituality and Psychosis," 170–71.
26. Ibid.

phrenia is a breakdown in the relation between thought, emotion, and behavior, leading to faulty perceptions of the world. It often involves a group of disorders: in this case, the word "affective" means how moods and emotions are expressed. So Bill is diagnosed as a person with schizophrenia who has a noticeable shift in his mood swings. The recognition that he has chronic underlying psychosis with persecutory delusional themes means he thinks people are out to get him. Bill's current situation is this: single, unemployed, living alone, with an eighteen-year history of illness with hospitalization. This could fit many persons living with a mental illness like schizophrenia. It is a disabling disease that isolates one from community, prevents regular employment, and periodically flares up into hospitalization, so that one's life may take an abrupt turn for weeks. One other aspect that many patients have is an addiction to street drugs, alcohol, and/or tobacco.

> During episodes of psychotic depression, the patient had been in torment over his "sins," particularly masturbation. He would react violently if it was suggested that masturbation was normal. When his mood was elevated, he would pursue anti-abortion activities, occasionally becoming violent. He had delusions of grandeur relating to themes of God. . . . He demanded to know if his psychiatrist was an abortionist. . . . He had been banned by radio stations for making nuisance calls. . . . When mildly depressed, he would be most in touch with reality and would become aware of his losses. The therapeutic relationship tended to fluctuate and trust was highly variable.[27]

The second paragraph describes Bill's moods. With regard to the experiential dimensions of delusion, outlined previously, we can see clear evidence of the "emotional affect" (negative effect) and "impact on your life." First, the emotional impact is indicated by the words used to describe his feelings: "depression," "torment," "reacts violently." The word "torment" suggests great pain due to his psychotic depression. Notice the strength of his feelings: there is a great deal of anger expressed, perhaps due in part to his delusions of grandeur relating to themes of God. He suddenly feels powerful enough to take on the abortion clinics and do so in the name of God. He "demands to know" if his psychiatrist is an

27. Ibid.

abortionist. Bill goes from torment to anger. This emotional roller coaster can be exhausting.

The "impact on your life" is described next: "pursue anti-abortion campaign activities, occasionally becoming violent. . . . banned by the radio station for making nuisance calls." This is manic behavior that can lead to negative consequences. Bill's nuisance phone calls would alarm me because it suggests he is acting on his feelings of power and righteousness. His anti-abortion campaigning can become violent—that suggests possible legal consequences. Either behavior could return him to a forensic psychiatric hospital.

When Bill's mood levels off and he is slightly depressed, he is able to become aware of the losses in his life and is able to experience the sadness and loneliness that are the realities of his life. This is the most telling sentence in the case study. Even though he has lived with his illness for eighteen years, is it a stretch to think that one of those times he might attempt suicide?

> Part of the therapeutic contract was to avoid direct action in anti-abortion activism for reasons to do with his personal safety. He agreed to the therapist's suggestion of constructive use of religious outlets at times of crisis. The patient appreciated opportunities to educate his psychiatrist about Catholicism.[28]

The third paragraph is a summary of the work of Bill's therapist, but also highlights the place where the chaplain could play a role as his religious friend. The therapist has created a therapeutic alliance with Bill. This allows him to suggest alternate behaviors for Bill when his mood is elevated. The therapist wisely found a *religious* alternative outlet during the times of crisis. Here is where it is helpful to know if Bill's support network includes the priest. That kind of information can be gleaned from a spiritual assessment.

It is surprising to me that the man's religious life is being recognized and affirmed by the medical professionals; often this is not the case. Apparently the therapist has recognized the important role spirituality plays in Bill's life, and the psychiatrist's willingness to allow his patient to instruct him in Catholicism is encouraging. The professional respect the team demonstrates for Bill's spirituality would be a wonderful entry point for the chaplain, who could build on the team's respect and encourage

28. Ibid.

Bill by attending Mass with him or by spending time with him when he lives out his pro-life values.

A case study like this is a snapshot of the care of a person in treatment and can be a teaching tool for chaplains who want to learn how to care for a person diagnosed with a religious delusion. The chaplain might also want to present a case study outlining the differences between genuine spiritual experience and psychotic experience, as well as highlighting commonly held Catholic beliefs. The chaplain can be an important resource for the rest of the treatment team in this regard.

Conclusion: The Challenge

In a revealing study, Sylvia Mohr et al. compared patients with delusions with religious content to patients with delusions without religious content to see if one group fared better than the other.[29] Earlier studies had suggested that persons with delusions with religious content had a poorer prognosis in schizophrenia; the same studies showed that positive religious coping is frequent among this group. What the researchers found was that, "Patients who have persistent delusions with religious content...frequently feature antagonism with psychiatric care and get less support from their religious *communities*."[30] Mohr explains the difficulty: "Delusions with religious content were an obstacle to participation in religious activities with other people and support from a religious community...due to the dysfunctional behaviors related to their delusions." As a result, these patients "kept their distance from both psychiatric care and religious communities."[31]

The challenge for chaplains is to learn how to reach out to people that have delusions with religious content, both in the hospital and in the community. These persons can be behaviorally difficult and disruptive. They may require a great deal of time from the pastor. A congregation might be apprehensive and fearful about such a person. Thoughtful preparation will need to be given to ministering to a person with these needs. But the studies mentioned above indicate that positive spiritual coping benefits these people and allows them to live a richer life.

29. Sylvia Mohr, Laurence Borras, Carine Betrisey, Brandt Pierre-Yves, Christiane Gillieron, and Philippe Hugueler, "Delusions with Religious Content in Patients with Psychosis: How They Interact with Spiritual Coping," *Psychiatry*, vol. 73, no. 2 (2010): 158–72.

30. Ibid., 167, my emphasis.

31. Ibid., 167–68.

Tom had been living in the community for several years when he phoned me about a church he wanted to attend. I suggested that he not reveal his "identity" too quickly. Of course, that was the first comment he made when he entered the church! But the greeter simply escorted him to a seat. I met with the pastor several times to talk about Tom's participation in the church. It was bumpy. At times, Tom refused any counsel from the pastor, while at other times he received it. After two years, Tom left the church and tried a few others. That lasted only for a short time.

For the chaplain or congregation that is willing to invest the time and effort it takes to create and sustain a relationship with persons like Bill or Tom, the experience can be rewarding. You may learn how to survive living under a bridge, as I learned from Raymond. Or, they may show you the best places to go dumpster diving. They will introduce you to a world you would not normally frequent—and do it all on a limited disability pension. God's bias for the poor and marginalized is clear biblically—and this includes persons with mental illness. Spiritually, persons living with a chronic mental illness and who carry all their earthly possessions in a shopping cart challenge our materialistic values. Pastorally, the weak give the strong an opportunity to practice humble foot washing. And in so doing you will truly meet Jesus Christ: "For I was hungry and you gave me food, I was thirsty, and you give me drink. I was a stranger and you welcomed me. I was naked and you clothed me. I was sick and you visited me. I was in prison and you came to me… inasmuch as you did it to one of the least of these my brothers or sisters, you did it to me" (Matthew 25:35–36, 40b).