Self-belief: holistic psychiatry in a secular age

Commentary on . . . Holistic psychiatry without the whole self†

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Summary Charles Taylor provides important philosophical accounts of what it means to be a 'self' in a secular age. Psychiatry has not traditionally concerned itself with other than limited accounts of the concept of the self but Taylor's work sheds a revealing light on the challenges to be met by aspirations to an holistic practice of psychiatry in our secular age.

Declaration of interest C.C.H.C. is Chair of the Spirituality and Psychiatry Special Interest Group (SPSIG) at the Royal College of Psychiatrists. The views expressed in this article are his own. The SPSIG does not adopt any particular position in relation to the matters debated in this article, but welcomes open debate about this and other matters related to spirituality and psychiatry, both in publication and at its meetings. C.C.H.C. is an Anglican priest.

In this issue of *The Psychiatrist* David Crossley is right to draw attention to the importance of Charles Taylor's accounts of the nature of modern identity and secular society for the practice of psychiatry in the Western world today.[1] Neither *Sources of the Self*[2] nor *A Secular Age*[3] are books that most psychiatrists will read, but they have important implications for the practice of psychiatry. Taylor draws attention to the moral dimension of our understanding of what kind of self it is good to be, and to the particular form that this now takes for us in the context of our secular age. The context of the self in secular society importantly defines the way in which we all see ourselves as selves when we are well and flourishing, a self-perception that is significantly distorted when mental disorders intrude upon and impair our well-being. Yet, contemporary Western psychiatry displays a surprising lack of interest in such fundamental concepts of selfhood and identity, preferring to concern itself with understanding the nature and boundaries of pathology. Although agreeing with almost all that Crossley has to say on all of this, I would wish to present the implications for the practice of holistic psychiatry slightly differently.

Psychiatry and Taylor's account of the self

For Crossley, Taylor 'draws out a tension between seeing the self as a self-responsible agent disengaged from and acting instrumentally in the world and contrasting attempts to envisage it in broader, more holistic terms'.[1] This seems to imply that the self envisaged as disengaged and buffered from the world around it is thereby seen in less holistic terms. Although I share Crossley's and Taylor's concerns about the plight of the disengaged and buffered self, I am not sure that it is strictly fair to say that the disengaged self does not have its own holistic self-understanding. Furthermore, Taylor's account of the buffered and disengaged self is clearly a very holistic one indeed. The problem is, rather, that we do not have any socially shared account of the holistic context within which the self is set (or indeed even on the nature of the self that occupies this context). I would thus not wish to question whether there can 'ever be an adequate model of holistic care' so much as whether there is any hope that we might find a socially shared model of holistic care in our contemporary secular and pluralistic society.

Taylor's account of things suggests that we are more aware of the inwardness of our self-identity than ever before and that this self is both 'buffered' and 'disengaged'. These terms are nuanced, and are subjected by Taylor to lengthy analysis. It is therefore easy to oversimplify things. However, it might be said that this account of the self emphasises our individual inner sense of ourselves as able to view the world around us objectively and dispassionately, each from our own individual perspective. When mental disorder intervenes (a scenario that Taylor does not address at any length), this sense of self and its perceptions of itself and of the world around it, might be distorted or undermined, thus impeding human flourishing and creating intra- and interpersonal disharmony. However, the therapeutic goal (according to this understanding of the self) would still be to return the self to its 'healthy' state of disengaged

†See special article, pp. 97–100, this issue.

objectivity. Thus, for example, the alcohol-dependent drinker may need help with finding a more objective and realistic perspective upon their behaviour and its impact on both themselves and those around them. Or, again, the person who has experienced a deeply traumatising event, which they either deliberately or unconsciously avoid reminders of, may need help with regaining a degree of objectivity about what has happened to them and its impact on themselves and those around them.

There are clearly problems associated with this sense of the self, many of which Taylor draws attention to. In particular, it is now clear that our disengagement does not make any of us as objective as we would like to think that we are and that it can leave us feeling isolated and alone as much as it may buffer us from the threatening world around. However, it is not immediately obvious that this perspective on the self should prevent psychiatry from being 'holistic' in the usual sense of taking into account all aspects of what it is to be human and avoiding a narrow focus on only limited (for example, only physical or psychological) aspects of the whole. After all, a good clinician should be able to elicit an account or narrative of what it is like to be any given patient's particular self and thus what the self-determined and self-contextualised priorities for treatment are. If these are too impaired by pathology to be accessible, then therapy can aspire to enabling a self to recover or redefine her own account of what this flourishing might look like. These tasks do not seem to me to be insuperable. We can ask what recovery might look like, within the self-understanding of the person whom we seek to help, and this can be holistic within its own terms. Unfortunately, the clinical task, if the clinician aspires to being holistic, is further complicated by Taylor's account of the secular context within which the self is set.

Holistic psychiatry in a secular age

According to Taylor, our secular age manifests its own collective malaise. This 'malaise of modernity' (also referred to by Taylor as the 'malaise of immanence') is characterised by a loss of meaning and transcendence, and by 'cross-pressures' that act upon the self so that it finds itself torn between orthodox religious belief and unbelief. As a result of these cross-pressures, a 'nova effect' has been set in train, by way of which an 'ever-widening variety of moral/spiritual options'[3] has been generated, each of which offers its own 'third way' as an alternative to the unattractive and polarised extremes of traditional belief and unbelief. Although the wider culture affirms the authenticity of individual discovery and expression of sources of personal fulfilment based on these nova spiritualities, it also generates a process of 'mutual fragilisation' that renders each of them insecure. Taylor attributes this to a pluralism that brings us into closer contact with others than ever before. Within this pluralistic society we find not only that others hold very different beliefs from us, but also that they are deeply like us. The contradictory, and yet apparently equally authentic, beliefs that we encounter in ourselves and others thus appear to mutually invalidate (or 'fragilise') each other. Expressive individualism is affirmed, but at the same time the individual convictions that it generates are rendered fragile and vulnerable, lacking the certainties that gave security to previous generations. It is this phenomenon, rather than the buffering and disengagement of the self *per se*, which I would argue renders the clinical encounter both problematic and treacherous.

When in contact with health services, the cross-pressured self must make itself vulnerable to the clinician. At best, the clinician may be expected to have adopted her own moral and spiritual beliefs, beliefs that may implicitly invalidate (or fragilise) those of the patient. At worst, the clinician may be seen as an agent of the cross-currents that explicitly generate fragility of the self, currents that threaten further loss of belief just at the time (i.e. the time of illness or crisis) when belief may be seen as most important as a coping resource. And, in this context, 'belief' may equally be represented by belief or by confident unbelief. Thus, the patient who is an atheist (for example) may no more wish to see a confidently Christian psychiatrist than the patient who is a Christian may wish to see a confidently atheist psychiatrist (although there is reason to believe that the latter scenario is statistically more common[4]). This, among other reasons, is why I would not normally wish to disclose my own beliefs to my patients. However, being aware as I must be of my own beliefs when I engage in clinical work, I must also be sensitive to ensure that these beliefs do not subtly or covertly impinge upon the way in which I discuss my patient's beliefs. Further, I must be constantly alert to ways in which I can help to affirm rather than further fragilise my patient's beliefs at a time when they most need them.

Any clinician who wishes to be truly holistic must therefore find authentic ways of addressing those dimensions of patient care that concern belief (including unbelief) systems that are either consonant with or contrary to their own. It is clearly the contrary state of affairs that causes most problems, and it may be for this reason that holistic care is sometimes best provided within the context of a faith-based organisation.[5] However, I do not believe that holistic care is unattainable when patient and clinician find themselves in places of contrary meaning. Doubtless, the differences sometimes need to be openly acknowledged, and this may sometimes require that a chaplain or other representative of a faith community or spiritual tradition be brought alongside to help. However, very often, the sensitive and empathic clinician can affirm a contrary source of meaning to their own simply by showing respect for it, and by allowing adequate space within which it may be expressed, explored and brought to bear upon the presenting problem or disorder. Such good practice would indeed be likely to follow the guidelines of the American Psychiatric Association,[6] or recommendations recently adopted by the Royal College of Psychiatrists.[7] However, I would not call this a 'disengaged stance', since a disengaged stance is one that objectifies and withdraws from the other, and Taylor specifically cautions that this can be the wrong way to go about achieving understanding in such contexts as the pursuit of psychology, or in personal relationships in everyday life, or (I would add) psychiatry (see *A Secular Age*, p. 285).[2] It is empathy that is required in clinical engagement, not the dubious objectivity of disengagement.

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Person-centred psychiatry

I also find myself concerned at the assertion that it is a good way forward, in the pursuit of an holistic practice of psychiatry, to focus primarily either on negative concepts such as shame (although doubtless they have their part to play) or on a repersonalisation of the training of psychiatrists (although this doubtless is also important). To be both person-centred and scientific is not insuperably problematic, as long as we remember that good psychiatry is about more than just the application of science. To practice psychiatry well the clinician must be empathic, non-judgemental and authentic. In order to practice holistic psychiatry, the clinician must elicit and understand sources of meaning that may be alien to their own and not allow these to be either threatening or self-invalidating. Whereas usually it will not be appropriate for the psychiatrist to convey to the patient, in reciprocal fashion, their own sources of meaning, if they do, this will also be undertaken in a non-threatening way and will be for the good of the patient (taking into account their beliefs) not for the good of the clinician or for the promotion of any cause that would further fragilise the patient's healthy self-understanding. (General Medical Council guidance clearly recognises these issues (para. 33)[8] and (para. 19)[9]).

Arguably some self-understandings are fragile not because of the malaise of immanence but because they arise from some other personal or social pathology that renders them inherently unhealthy. It is for this reason that Koenig urges us to consider the possible clinical need to challenge beliefs that are 'contributing to or intertwined with psychopathology',[10] but this is, as Koenig acknowledges, a risky matter and is difficult to judge professionally and ethically. It is perhaps, tempting to argue from such difficult cases that we cannot make any objective judgement about sources of self-understanding in any case, and thus that matters such as religion and spirituality should be excluded from all clinical practice.[11] However, based on my own clinical experience, I would suggest that such cases do not make the basis for good norms of clinical practice and they are best addressed by a collaborative approach with patient, family and faith community, rather than by exclusion from clinical attention.

In conclusion

In his article Crossley draws our attention to the important way in which language about mental illness can suggest a particular moral status, and that professional help is often necessary in resolving the ensuing tensions. We do well to heed his call to the challenging and sensitive clinical task of trying to understand the implications of what our patients think and say about themselves and their beliefs.

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