

Distinguishing Denial From Authentic Faith in Miracles: A Clinical-Pastoral Approach

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Is it possible to distinguish between authentic religious faith in a miraculous cure and the psychiatric syndrome of denial in the face of serious illness? There are, of course, atheists who consider all religious beliefs delusional, and, therefore, would not accept the meaningfulness of the distinction. Many others, however, including some persons of faith, might still demur before undertaking such a task. They might, at first pass, think that the attempt to distinguish between genuine faith and psychological denial is either disrespectful toward the patient, intolerant, or an impossible task, given what is taken to be the inherently private nature of religious matters. For these critics, the notion that anyone other than the individual could make a judgment about the authenticity of the faith of another is itself morally offensive. What seems at first the morally correct response might seem to be, "How could one dare to question the authenticity of the religious views of another person?" Yet, such a view, upon careful analysis, is no less dismissive of the religious person than the view of the "hard-nosed" atheist. The assertion that it is impossible to distinguish authentic faith from a disordered psychiatric state could only be true if faith were taken to be at least functionally equivalent to a disordered psychiatric state. Such an assumption could hardly be construed as reflecting an attitude of respect for religious persons, or evidence of the kind of tolerance that ought to characterize a liberal polity. Therefore, contrary to many people's initial impressions, it is deeply insulting to religious persons to suggest that expressions of belief in miracles cannot be questioned.

Important clinical observations support this view. It is a well-known fact that mentally ill persons not infrequently use religious language. Except in unusual cases, such as malingering, this is usually not a conscious manipulation of reli-

gion but one among many possible clinical manifestations of the psychiatric disease. All clinicians are aware of this. If the patient in the emergency room shouts, "I am Jesus Christ, and I condemn all of you to hell," most physicians and nurses know that they should call the psychiatrist, not the chaplain or the ethicist.

The view that an individual's belief in miracles ought to be susceptible to challenge is also supported by a careful philosophy of religion. As I argue in another paper in this issue of the *Southern Medical Journal*, the rhetoric of privacy and religion can lead to logical inconsistencies.¹ Properly understood, respect for the privacy of religious belief ought to imply tolerance, not a purely subjective epistemology of religion. Tolerance means that there should be no imposition of religious beliefs upon individuals by the state (or by physicians) in a pluralistic and tolerant society. Unfortunately, the notion of respect for the privacy of religious belief is often amplified beyond this moral notion of tolerance to imply a

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subjective epistemology of religion, ie, the notion that all religious beliefs are inherently subjective and that individual religious beliefs are not susceptible to challenge. As I have argued, however, private religion is just as incoherent as the notion of private language.² If one believes that there are religious truths, as the religious person must, one must also accept the existence of a criterion by which to judge the truth of any given religious claim. If one's standard for judging the truth of one's private religious claim were itself private and subjective, that subjective standard would, in turn, need its own objective truth criterion, and so on, in

an infinite regress of subjectivity. A believing person must hold that his or her religion expresses at least some truths; otherwise, it would not be worth believing. But the criterion for judging the truth of a religious claim must be something other than that person's own subjectivity.

Where could such a truth criterion be found? That criterion must be the deposit of faith of that person's religion. This will at least be an intersubjective criterion of truth. Religions are believing communities. Whether any particular religion would go further than intersubjectivity and claim an objective criterion (such as revelation or scripture) will depend upon the creed of that religion. But the criterion for assessing an individual's beliefs must be outside that individual. Claims about miracles may therefore be subjected to scrutiny according to the criteria of the patient's faith.

Faith is, in this sense, public and not private. Judging the authenticity of patients' or families' claims about miracles therefore involves examining such claims in light of the deposit of faith of the person's own religious tradition.

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0038-4348/0-2000/10000-1268

Denial, Psychology, and Spirituality

Establishing that one must, in principle, be able to distinguish between authentic faith in miracles and the psychological syndrome of denial does not mean that actually making this distinction will at all be easy in any clinical case. Teasing apart the psychiatric and the religious might be obvious and easy when treating a delusional schizophrenic, but it can be much more subtle and difficult in other cases. For instance, Catholic confessional theology has developed the idea of a spiritual state called “scrupulosity,” in which penitents return very frequently to confession due to excessive fear of damnation, intense consciousness of sinfulness, and insufficient faith in the mercy of God.³ But consider a person who returns to the confessional ten minutes after his last confession because he fears that his previous confession was sinfully insincere, who repeats this cycle three times in a single day. Such a person is more likely to be suffering from obsessive-compulsive disorder than simple scrupulosity. The spectrum along which such distinctions are arrayed is very broad, however, and one state blends easily into the next. Is a twice-weekly penitent pious, scrupulous, or suffering from obsessive-compulsive disorder? Sometimes it can be hard to tell.

Likewise, distinguishing denial from authentic belief in miracles is easy if the patient is psychotic, has obviously disordered thinking, and suffers from a host of other delusions. In many actual clinical cases, however, the distinction will be much more subtle.

Denial is a psychological state that occurs frequently in healthcare. Kubler-Ross called it one of the “stages” through which dying persons pass, although most ethicists and specialists in end-of-life care now agree that it is but one of many possible reactions to terminal illness and need not be part of an ordered sequence of psychological stages.^{4,5} Families who refuse to authorize the discontinuation of life-sustaining therapies that the physicians have deemed futile are frequently thought to be in denial. Some of these persons may also be religious, and some of them will invoke explicitly religious language in explaining their decisions to continue life-sustaining treatment. Should the use of religious language by patients or families, such as “Don’t stop the ventilator. I’m praying for a miracle,” preclude consideration of whether they might be in denial? Out of respect for the patients and their families and their religious beliefs, the answer ought to be no.

Dealing with denial is often difficult of itself. If one believes that patients can authentically pray for miracles, however, new complications are added. How might anyone go about trying to make a clinical-pastoral determination whether prayers for a miraculous recovery represent authentic reli-

gious faith or a manifestation of a disordered psychological state? Such tricky currents will obviously be extremely difficult to navigate.

Few attempts have been made in the literature to address the distinction between faith and psychological denial.⁶ Denial is defined as a “defense mechanism in which the existence of unpleasant realities is disavowed; refers to keeping out of conscious awareness any aspects of external reality that, if acknowledged, would produce anxiety.”⁷ It is important to recognize denial in patients and in families.

Sometimes denial is a functional defense mechanism. The pain of the imminent loss of a loved one can be so great that, for some, denial is a bulwark against the pain. Wise clinicians often tolerate a fair amount of denial in patients and families. Bludgeoning them with the truth can be quite malevolent. Judging the authenticity of patients’ or families’ claims about miracles therefore involves examining such claims in light of the deposit of faith of the person’s own religious tradition.

But denial can also become dysfunctional. It is not beneficial to inflict painful and futile treatments upon a patient who is in denial. One must also be cognizant of the fact that direct-current countershock of the patient is not an effective way to treat her family’s denial. The fact that families or patients use religious language ought not preclude some investigation of whether they are in denial. Talk of miracles in the face of physicians’ determination that the patient is inevitably and irreversibly dying might be an expression of genuine religious faith. Or it might be denial. Some way to judge between these two would be helpful to clinicians regardless of whether the situation warrants any sort of intervention.

A few caveats are necessary for this discussion to proceed.

1) The questions I propose are most useful if the patient is a member of a faith community with organized beliefs against which to judge the patient’s beliefs. If a patient does not belong to a faith community, then it is much harder to use these questions because the standard against which to judge the patient’s beliefs could consist only in very broad and general principles drawn from the history and sociology of religion. As I discussed in my introductory article in this special issue, there really are no private religions or private miracles. For patients who have no religious affiliation yet are praying for miracles, one would need to rely more upon a judgment that the patient’s idiosyncratic belief, spiritual or not, is functional or dysfunctional.

2) The questions I will suggest fit best with the Abrahamic family of faith traditions and may not generalize to other

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belief systems. Nonetheless, this is precisely the context in which this issue most frequently arises in North America, and much could be drawn from these questions in applying them to other situations.

3) These questions are definitely *not* intended as a script for physicians. It is probably not a good idea for an unaided physician to try to distinguish denial from authentic belief in miracles, and almost never would it be appropriate for a physician to challenge a patient's religious beliefs directly without help. Rather, based on observations, indirect questioning, and much listening, the clinician may gather a better understanding of the situation by having worked through the questions on this list. If the physician is not of the patient's own faith community, it will be extremely difficult, if not impossible, for the physician to know the criterion by which to judge the authenticity of the patient's claims. The physician might not even have a firm enough grasp of his or her own religion to discern the authenticity of the miracle claims or miracle petitions of a patient with whom the physician shares a common faith. And if the patient is to be *challenged* about his or her belief in miracles, this is best done by members of the patient's own family, congregation, or clergy, or by experienced members of the pastoral care staff, in concert and in coordination with the physicians and nurses. Physicians ought not attempt to challenge patients' faith in miracles without competent assistance.

4) Coming to a judgment that a patient is in denial is not itself a warrant for any intervention by the treating team. How one acts upon the clinical judgment that the patient is in denial will depend upon the circumstances. As with any form of denial, there are times when such a defense mechanism is functional. Intervention is generally warranted only when the denial has become dysfunctional.

Aware of these caveats, and also mindful that the proposed list is hardly exhaustive, the following five questions may be useful in distinguishing between authentic faith in miracles and the psychiatric state of denial:

1. Does the patient acknowledge the possibility that the answer to the prayer for a miracle may be "no"? Religion is not magic. As I have explained elsewhere in this issue, petition is not conjury.¹ Religious historians and sociologists argue that across denominations and cultures, the religious individual does not attempt to manipulate or control God's power, but makes real needs and desires known to the Divine and then disposes him/herself to the divine will.^{8,9} If the patient or family cannot acknowledge the possibility that the answer to the question is up to God and not up to them, there is reason to suspect that they are in denial. If the patient says, "I'm praying for a miracle, but God's will be done," the patient's beliefs are more likely to represent authentic belief in miracles and not a form of denial.

2. Is the patient able to acknowledge that God might not need the doctors to perform the hoped-for miracle? If

the patient subscribes to a belief in an omnipotent God, then it is not necessary that God rely upon physicians to perform the miracle.¹⁰ I am unaware of any organized form of religious belief that instructs believers to insist that physicians perform every conceivable intervention, even if the physicians are convinced that it will not work, to assist God in performing a miracle. Cultural factors, such as historical injustices and lack of access to care, leading to the suspicion that physicians may be withholding costly but potentially efficacious treatment, might actually be more at play than religious beliefs per se in disagreements about whether to stop treatment.^{11,12} Some patients may also interpret giving consent to stop treatment as giving up on God before God has given up on them.^{12,13} Yet neither of these interpretations implies a belief that God absolutely needs the physician to continue life-sustaining or other treatments as a prelude to the miracle. Consider even the case of the patient who believes he must pray for a miracle as a test of faith from God, claiming that treatment cannot be discontinued because the longer the situation continues, the bleaker the patient's medical prospects, the more the faith that is required to believe in the miracle and therefore the greater God's favor will be toward the believer. Such a "test-of-faith" interpretation need not, however, depend on continuing medical treatments. In fact, that the physicians had given up believing they could cure the patient could only make the prognosis bleaker and the faith needed to expect the miracle even greater than if they continued treatment. Thus, strictly speaking, the "test of faith" would be more rigorous if the physicians were to stop treatment and patients should not be able to insist on unwarranted treatments on this basis. By contrast, a patient praying for a miracle might, for instance, accept a "Do Not Resuscitate" order, based on a belief that, should his heart stop, it would be a sign of God's will that he should no longer resist death, all the while expecting that a cure will happen instead.

Importantly, patients insisting on treatment, while using religious language, may not really be doing so because of a faith in a miraculous cure. Patients who demand all conceivable treatments may be expressing distrust in physicians. If so, the distrust must be addressed. They might, alternatively, be in denial. If so, the denial must be addressed. But distrust and denial ought not be confused with authentic faith in the miraculous power of the Divine.

3. What is the effect of the patient's belief system on the patient's overall mood, sense of well-being, and sense of self? Patients who are using denial as a defense mechanism do so because they are fearful,^{4,14} whether they express this denial in religious language or not. A patient who prays for a miracle but also prays for peace, and/or appears to the team caring for him as genuinely to be at peace, is less likely to be in denial than a patient who prays for a miracle but appears anxious and fearful. If the belief in miracles is a religious

expression of a psychological state of denial, it will often be associated with outbursts or demands that are upsetting or disruptive to the team or other patients and their families. Genuine faith in miracles ought not make the patient more anxious, fearful, angry, or hostile.

4. What are the effects of the patient's beliefs on relationships with others—family, friends, religious community, and staff? Negative forms of religious coping lead to isolation.^{15–17} A clue that the expressed belief in miracles is actually a form of negative religious coping is the devolution of conversations with the patient into a delicate dance in which the team struggles to avoid a clash in perceptions of reality. The effect of this form of conversation is that it isolates the patient from the possibility of deep sharing with others. At other times, conversations between patients in denial and their families become a form of co-conspiracy with all sharing in the denial.¹⁸ In this situation, the focus shifts away from the patient, away from a need for reconciliation within the family, away from the possibility of deep interpersonal sharing. All these important needs are replaced by a fixed focus on the expected miracle. By contrast, a patient praying for a miracle who is affable, aware of the needs of others and perhaps praying for them as well, and in close communication with his family, friends, congregation, and the staff, is less likely to be in denial.

5. Is the patient willing to accept input regarding God's will from others in his or her own faith community? The religious person who awaits a miracle is typically part of a worshipping community and is open to that community's discernment of God's will.^{6,19} As I have argued, there is no private religion and there are no private miracles. Miracles are, by their nature, shared by a believing community and only make sense in the context of a believing community. Religious persons who resist the input of family, clergy, and fellow congregants are more likely to be in denial. The "spiritual but not religious" patient is not typically the type of patient who holds out for a miracle, but if the patient has no religion and is holding out for a miraculous cure, one should be careful that the patient's idiosyncratic religious beliefs are not a form of denial. A patient who, while praying for a miracle, states that she is open to the input of others, is less likely to be in denial than a patient who refuses to speak about his or her beliefs to hospital chaplains or to her own clergy.

These questions should be of practical assistance to clinical teams, composed of physicians, nurses, and chaplains, attempting to make a clinical judgment of whether a patient is in denial or expressing authentic religious faith in miracles. However, the reader should realize that this system is based upon knowledge and experience and has not been tested empirically.

When to Intervene?

Having made a judgment that the patient is in denial, one does not thereby have a warrant to intervene. In general, that can only be done when the patient's denial has become so dysfunctional that it must be challenged for the patient's own good, or the family's denial must be challenged for their good and the good of the patient. When the conditions for such an intervention have been met is another question for another paper. But making a clinical-pastoral judgment that the patient is actually in denial is a necessary first step. It helps to understand how best to support the patient. It can help make sense of the patient's isolation or the family's anger and thereby help staff to manage these emotions. As I have stated, challenges to denial couched in religious language should not come from the medical staff alone but from other family members, pastoral care staff, or the patient's clergy who will be both better equipped to understand how the miraculous petitions or claims square with the patient or family's religion and how best to steer the patient to a more authentic faith and a more functional approach to dealing with the illness at hand.

Making a clinical-pastoral judgment that the patient is actually in denial is a necessary first step. It helps to understand how best to support the patient.

A Final Caution

On rare occasions, the patient's own faith community will not accept questions 1 and 2, refusing to acknowledge that God may say "no" to the prayer, or insisting that God indeed does need the physicians to continue treatment to perform the expected miracle. Further complicating matters, it may be the case that the faith community sees its duty, along the lines of question 5, to reinforce the patient's refusal to make these acknowledgments.

One could certainly challenge these theological positions on theological grounds. However, such a conversation with the patient's faith community would require a great deal of time and respectful interfaith dialogue and would not seem to offer any immediate assistance to a clinician caring for the patient. Making a diagnosis of denial on the basis of questions 3 and 4 alone (ie, upon the effects of the patient's beliefs on the patient's own psychological state and relationships with others) might still be possible, but will be much more difficult if the faith community refuses to acknowledge questions 1 and 2. Ironically, these cases leave one in the same situation as if the patient were expressing a spiritual belief in miracles without any commitment to a particular religious community. One might not be able to judge that the patient or family is in denial. One might, however, still make judgments about whether the beliefs are functional or dysfunctional and one does have a warrant to act if the beliefs have become grossly dysfunctional.

Intervention can be justified if the situation reaches one of the following three conditions: (1) Requests for medical care reach the point of conscientious objection on the part of

the clinicians (ie, the physician might be asked to do something to which the physician is morally opposed), and this might be respectfully refused. Or, (2) demands are made for care that is biomedically futile (ie, the patient or family may request a treatment that, to a reasonable degree of medical certitude, will not work from a strictly biomedical point of view), and such interventions might be respectfully refused. (3) It may be the case that the clinician feels that what the family is requesting might only harm the patient with no reasonable prospect of affecting the disease, and such interventions might also be respectfully refused. Under such circumstances, it is justifiable for the clinicians involved to make a respectful but firm refusal to carry out the requested therapeutic or diagnostic intervention, even if it cannot be determined whether the patient or family is in denial. Such a policy would set a higher threshold for refusal than that suggested by Savulescu and Clarke but still establish outer limits on what could be requested in the name of faith in miracles.²⁰ Like an intervention to confront denial, a discussion with the patient or family about why their request will not be granted would require compassion, sensitivity, and considerable communication skills. But the fact that the request was framed in terms of belief in miracles should not preclude the application of the same standards one would use in refusing requests from patients who do not frame such requests in religious terms.

Above all, one should bear in mind that most patients and families who pray for miraculous cures are not in denial and are not demanding immoral, irrational, or malevolent interventions. Their faith should be supported, not ridiculed. The framework suggested here should be useful to clinicians who seek to help that small number of patients and families for whom the defense mechanism of denial, framed in the language of miracles, has become the principal manner by which they face their most profound fears.

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