
Epilogue: Proposal for a World Psychiatric Association Consensus or Position Statement on Spirituality and Religion in Psychiatry

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E.1 INTRODUCTION

In 2004, one of us (PJV) wrote a discussion paper entitled 'Religion, spirituality and psychiatry: A field wide open for discussion and research' [1] and in 2005, on behalf of the World Psychiatric Association (WPA) Section on Religion, Spirituality and Psychiatry (SRSP¹), this was circulated amongst colleagues around the world as a basis for discussion. Amongst other groups, this paper was sent to the Spirituality and Psychiatry Special Interest Group (SIG) of the Royal College of Psychiatrists in London, United Kingdom. It was agreed by the SIG and the SRSP that there might be benefit in agreement by WPA on a shorter position paper on the same theme. In November 2006 the SIG and the SRSP agreed to work together on this important project. A position paper was duly drafted, also by one of us (CCHC), and approved by the Executive Committee of the SIG.

¹ The section was founded in 2003 during a WPA conference in Vienna; Chairman Professor H.M. van Praag, Vice-chairman Professor Driss Moussaoui (Morocco), Secretary Peter J. Verhagen. The sections, currently more than 60, play an important part in the WPA organization, since the sections include an assembly of experts and are obliged to develop activities (symposiums, research, training) aimed at drawing attention to the specific fields of expertise of these sections worldwide and regionally.

The SIG and the SRSP hoped that the content of its proposed position statement would facilitate discussion within the WPA about what might be agreed amongst psychiatrists concerning spirituality and religion. As a starting point, the SIG considered that the position statement should aim for clarity (as far as possible in a short document) about the nature of spirituality and religion. The SIG felt that the statement should say something about the place of spirituality and religion within psychiatric assessment, training and research, and also that it should emphasize the need for respect of patients' beliefs, and affirm the need to work closely with faith communities. It also warned against proselytizing by psychiatrists amongst their patients.

The position statement prepared by the SIG was presented in 2006 to the SRSP of the WPA. A revised version of that document is published here for the first time (see appendix to this Epilogue, PROPOSAL). Following debate by the SRSP committee, it was eventually re-named as a draft consensus statement (CS), although we shall see that eventually discussion returned once more to the possibility that it might best be referred to as a position statement. The draft CS was duly circulated to appropriate bodies for international discussion. In the present chapter we will report on the subsequent international response to this document and offer our commentary on it. Amongst others, the Religion and Psychiatry Corresponding Committee of the American Psychiatric Association (APA) and the Asian Federation of Psychiatric Associations (AFPA) have made valuable contributions to debate about the CS, for which we are most grateful.

Difficulties arose in the process of international consultation which were unforeseen and unexpected. We will focus here on two important issues for debate: the relationship between religion and spirituality, and the significance of taking a spiritual history.

E.2 CONSENSUS STATEMENT: CRITERIA

Drawing up a consensus statement is one of the fundamental tasks set by the WPA, thus marking the great importance of such a document. What is its purpose? A consensus statement helps to express a consensus about a specific issue related to psychiatric practice, research and/or training within psychiatry worldwide. Therefore, before agreeing a consensus statement, all members of national psychiatric associations and organizations will be asked for their opinions and are invited to comment on the draft statement. Table E.2.1 gives an overview of the consensus statements which have been agreed to date. The titles give clear indication of the kinds of topics that have, for all kinds of reasons, been deemed worthy of such international attention. We personally believe that spirituality and religion in psychiatry is another such topic.

The WPA does not accept just any proposal for a consensus statement. In order to be considered worthy of such attention, a topic needs to fulfil a number of conditions. The topic has higher priority if:

1. It is a concern relevant to the further development of psychiatry around the world. Topics of only national or regional interest are given less priority. Topics of concern to several members (nationwide associations and organizations) gain higher priority.
2. Scientific evidence is available to support the importance of the topic. Topics which involve very complex and long-term evidence, and intensive commitment from experts, may be broken down into sub-sections to facilitate the process.

Table E.2.1 List of WPA Consensus Statements

(Access to the text of these statements is available through *WPA Online*, www.wpanet.org)

1. Consensus Statement on Psychiatry of the Elderly
(Approved by the General Assembly on 8 August 1999)
2. Consensus Statement on Psychiatric Rehabilitation
(Approved by the General Assembly on 26 August 2002)
3. Consensus Statement on Neurasthenia
(Approved by the General Assembly on 26 August 2002)
4. Consensus Statement on Preventive Psychiatry
(Approved by the General Assembly on 26 August 2002)
5. Consensus Statement on Second Generation Antipsychotic Medication
(Approved by the General Assembly on 26 August 2002)
6. Consensus Statement on Reducing Stigma on Older People with Psychiatric Disorders
(Approved by the General Assembly on 26 August 2002)
7. Consensus Statement on Disasters and Mental Health
(Approved by the General Assembly on 26 August 2002)
8. Consensus Statement on Globalization and Mental Health
(Approved by the General Assembly on 26 August 2002)
9. Yokohama Declaration
(Approved by the General Assembly on 26 August 2002)
10. Consensus Statement on Eastern Europe and the Balkans
(Approved by the General Assembly on 12 September 2005)
11. Consensus Statement on International Women's Mental Health
(Approved by the General Assembly on 12 September 2005)
12. Consensus Statement on Interpersonal Violence Against Women
(Approved by the General Assembly on 12 September 2005)
13. Consensus Statement on Physician Impairment with Mental Illness and/or Addictions
(Approved by the General Assembly on 12 September 2005)
14. Consensus Statement on Psychiatric Prevention and Health Promotion
(Approved by the General Assembly on 12 September 2005. This is a lightly edited version of the basic version presented in item 4 above)
15. Consensus Statement on the Use and Safety of Electroconvulsive Therapy
(Approved by the General Assembly on 12 September 2005)
16. Cairo Declaration on Mass Violence and Mental Health
(Approved by the General Assembly on 12 September 2005)

3. It is of greater public visibility and consequently likely to have more impact.
4. The absence of a consensus statement could be harmful to psychiatry or psychiatric patients.

The SRSP believed that these criteria provided sufficient justification to proceed with work on the CS for Spirituality and Religion in Psychiatry. In fact, in the SRSP's view, there seemed hardly any doubt about the relevance of the topic. Table E.2.2 gives an indication of the enormous numbers of people belonging to the world's major religions. Atheists comprise only 2.5% of the world population and non-religious people 12.8% [2, p. 67]. This is quite apart from the almost infinite diversity and continuing emergence of new religious groups [3].

We will now consider the four above-mentioned requirements for a CS, to see if a CS on psychiatry and religion could be considered eligible.

Table E.2.2 This List Includes Only Organized Religions and Excludes More Loosely Defined Groups Such as Chinese or African Traditional Religions

Religion	Members	Percentage
<i>Christianity</i>	2.1 billion	33.0%
<i>Islam</i>	1.3 billion	20.1%
<i>Hinduism</i>	851 million	13.3%
<i>Buddhism</i>	375 million	5.9%
<i>Sikhism</i>	25 million	0.4%
<i>Judaism</i>	15 million	0.2%
<i>Baha'ism</i>	7.5 million	0.1%
<i>Confucianism</i>	6.4 million	0.1%
<i>Jainism</i>	4.5 million	0.1%
<i>Shintoism</i>	2.8 million	<0.1%

E.2.1 Significance of the topic

It has repeatedly been argued that religion is a forgotten or lost dimension in psychiatry, but it is now commonly said that there is a growing awareness of the importance of religion and spirituality among psychiatrists and in mental healthcare. Some even speak of a 'silent revolution' which is taking place [5]. Psychiatrists once more recognize that their patients' spiritual experiences and religious practices are important. Religion and spirituality are again understood as positive sources of well-being, rather than pits of gloom-and-doom and psychopathological misery.

Is this 'silent revolution' taking place in the Netherlands, the United Kingdom and the rest of Western Europe, or is it confined perhaps to North America or elsewhere? Indications that it is occurring in the Netherlands are scarce. In the United Kingdom, the situation is perhaps rather more complex and it may be of value here to consider an example of this in a little more detail.

A recent editorial by Koenig [6] provoked a short, but rather fierce storm of correspondence in the *Psychiatric Bulletin* of the Royal College of Psychiatrists. What did Koenig argue? Firstly, he summarized data concerning two issues: that religion was said to be pathological, and that psychiatrists themselves are mostly 'non-religious' and often have a critical attitude towards religion. In his arguments he uses older, but also some relatively recent data [7]. These data provoked plenty of protests. For example, Koenig posits that 'only' 1.4% of the population in Great Britain are atheists. However, the 'World Christian Database' on which he relies for these figures is seen by some as 'hardly an unbiased source of information' [8]. According to Koenig's opponents, the correct number lies somewhere between 15.5 and 36% [9], although we might note that the 15.5% figure actually represents those who identify with 'no religion' rather than those who are actually atheists,² and the 36% figure applies to those of age 18 to 34 years.³

² <http://www.statistics.gov.uk/cci/nugget.asp?id=293>

³ <http://www.parliament.the-stationery-office.com/pa/ld200506/ldselect/ldbhc/128/5110211.htm>. This website also shows that figures from some other surveys are even higher. For example, a *Guardian* poll of 16-year-olds in 2004 found that 45% did not believe in God.

An interesting source for data, used by Lepping in his response, is the Religion Monitor (www.religionsmonitor.com) of the conservative German Bertelsmann Foundation [10]. These data indeed show that Great Britain is not the most religious country in a series of 18 countries surveyed. For example, on a scale of 1–5 concerning centrality of religiosity in life, Nigeria has the highest score (4.6) and Russia the lowest (2.4). Great Britain is the third lowest with 2.7; in comparison, the United States scores 3.9. [10, p. 160] So, religion would hardly appear to be as important a part of life in the United Kingdom as in the United States of America.

More important, however, are the objections against the proposals made by Koenig. Koenig pleads for the regular taking of a religious/spiritual history, for respect for supporting religious and spiritual beliefs, for challenging beliefs that are interwoven with or contribute to psychopathology, for praying with patients, and for consulting pastoral carers. What are the objections to these proposals? Poole et al. [9] argue that a spiritual history can be considered 'intrusive and excessive' and lacking in respect for 'non-believers'. Hilton [11] mentions that there is too little experience in taking a spiritual history, as opposed to a religious history. The process of supporting or challenging beliefs is also said to appeal too much to the norms and values of the physician, and to be incompatible with the 'therapeutic neutrality' that the clinician should adopt towards such matters. The introduction of prayer, a 'completely non-clinical' activity, into the clinical setting is said to represent a great danger of blurring boundaries and creating ambiguity around the therapeutic relationship [9].

All of these arguments are open to counter-arguments. It is not at all the case that a spiritual history is necessarily insensitive or disrespectful to those who do not hold a religious faith. Hilton herself notes that there is actually guidance about how to take a spiritual history on the Royal College of Psychiatrists website [12] and another correspondent [13], who declares himself an atheist, rightly suggests that taking a spiritual history is actually 'an easy task'. Koenig is cautious in his editorial about challenging belief and praying with patients, even if we might feel that his advice is more relevant to United States religious culture than in the United Kingdom, where there tends to be greater personal reserve about such matters. It also seems that the critics are not giving weight to the now large body of evidence that suggests a therapeutic benefit of taking account of spiritual and religious factors in mental healthcare [14]. However, the point here is not to detail the arguments for both sides so much as to acknowledge that there is a debate and that psychiatrists in the United Kingdom are not of one mind on these matters.

Some correspondents expressed concern that the then president of the Royal College of Psychiatrists apparently endorsed Koenig's arguments [15]. However, it should be noted that two other past presidents are on record as expressing similar support for the need to conduct spiritual or religious assessments in clinical practice, and generally to take religion and spirituality more seriously [16, 17].

In the United Kingdom at least, the situation would appear still to be one of movement and plurality. But, if we accept for a moment that a change of some kind appears to be in process, what might the explanation for this change be? One possible answer might be found in increasing interest in and knowledge of transcultural aspects of psychiatry. Within this movement, religious beliefs and practices are an important part of understanding the patient in cultural context. However, a more important explanation might be found in the observation that, despite all predictions to the contrary, religion has simply not disappeared from secular Western society.

Based on so-called theories of 'secularization', which emerged in the late nineteenth century and became popular in the 1950s and 1960s, it had been assumed by some that

religion would slowly but surely make way for a more secular social order, governed by more 'adult' and 'rational' ways of thinking. Whatever arguments sociologists may have about theories of secularization (and it would seem that there is much debate) the European Enlightenment has brought about a general separation of religion (now seen as a matter for private life) and public discourse. But now, more recently, the situation (as we have just seen exemplified by the debate amongst psychiatrists in the United Kingdom) appears to be changing. When and where did this change come about?

According to some experts, the Islamic revolution in Iran at the end of the 1970s could be seen as such a turning point [2]. Whether or not such factors have influenced thinking about religion in Europe, secularization has not carried the day, and has not occurred in other parts of the world at all. Thus a new hypothesis has gained ground: the transformation hypothesis.

This hypothesis suggests that religion does not return to the (public) stage unchanged. This becomes apparent from the fact that it is no longer adequate to speak about religion only, but always about religion *and* spirituality. In other words, the comeback of religion also implies a change in the concept we have of religion. Without going much deeper into this, an important element of that changing concept of religion seems to be that religion is no longer an all-encompassing phenomenon [18]. It is also possible to speak of a change in religious awareness, and change in understandings of the self.

These changes, the transformation of religion instead of its disappearance *and* the place spirituality occupies, are significant to psychiatry. With them comes a risk of improper medicalization or 'psychiatrizing' of unusual experiences, which could result in improper or even harmful psychiatric interventions. They require a renewed impulse for empirical and conceptual research into the distinction between religious and spiritual experiences on the one hand and pathological (not only psychotic) phenomena on the other hand. In addition, research is needed into the significance and effectiveness of religious and spiritual healing practices around the world. There are important differences in the way these phenomena and practices are approached, interpreted and evaluated, depending on cultural and subcultural contexts, values and sources. Based on these considerations, the SRSP holds the view that the topic of religion and spirituality concerns psychiatry worldwide and that consequently a consensus statement deserves high priority.

E.2.2 Scientific evidence

Extensive research has been conducted and comprehensive data are available, but the relationship between religion, spirituality and mental healthcare is still disputed. Indeed, there are some clear examples of a negative effect of spirituality or religion on mental health. Nevertheless, a majority of experts seem to agree that in general the relationship can be qualified as positive. Within this framework Koenig can be regarded as the champion in collecting and evaluating research [19, 20]. In a total of 724 quantitative studies before 2000 Koenig et al. found 476 studies that reported a positive association between religious involvement and a wide range of indicators for mental healthcare. In his earlier mentioned short contribution [6] he states that studies after 2000 confirm this picture. Indicators of mental health employed in such research include: fear, depression, suicide, addiction, abuse and trauma, self-image and self-esteem. However much of this research has been conducted in the West (mainly in the United States of America) and in Judeo-Christian groups of subjects. Therefore, much more research is needed from other parts of the world, in which studies

address subjects with different religious, spiritual and cultural backgrounds. Whatever the protests against Koenig's editorial, clinical practice should be based on good research.

E.2.3 'Public visibility'

Health is a political and public theme. Officially, religious and spiritual well-being are not part of the World Health Organization (WHO) definition of (mental) health.⁴ This is seen by many as a shortcoming of the definition, but arguably it is politically unrealistic to expect agreement on religious well-being. For, if governmental organizations were expected to pursue this, they would soon be accused of 'meddling with' religious issues. Besides, which religion(s) would be singled out? Such an approach would be likely to lead to hopeless complications. Yet, the religious domain is part of the 'Quality of Life' measures developed by the WHO. Religion and spirituality are sources of support and of coping in circumstances where life seems unmanageable. They can stimulate positive experiences such as hope and optimism, but also traditionally provide the means to cope with transitional phases in life such as birth, marriage, illness and death. There is, therefore, sufficient reason to learn to speak of a bio-psycho-socio-spiritual model.

E.2.4 And without a consensus statement?

Does it matter if there is no WPA CS on spirituality and religion in psychiatry? What should be underlined is that psychiatry is about more than just making a (DSM or ICD) diagnosis. In its programme 'Psychiatry for the Person' [22] the WPA pleads for the individual to be understood in his or her uniqueness and to be the focal point of clinical attention. Not to do so inevitably leads to deficient healthcare. But spiritual and religious concerns will often (even if, as some might argue, not always) be at the heart of that patient centred focus. A CS therefore provides important counterbalance in this programme to traditionalism and empiricism, and particularly the impoverished hyponarrativity of the DSM-tradition.

The SRSP have no doubt that a CS about psychiatry and religion would meet the demands set by the WPA, both as far as psychiatry itself is concerned, and also politically and socially worldwide. They see such a CS as harmonizing very well with WPA's ethical views [23]. This is not to deny that more scientific research is needed, or that there are cultural sensitivities to be addressed. (For example, in addition to the English language proposal of the CS, versions in other languages would need to be formulated: especially in Spanish, Arabic, and at least one Asian language).

Notwithstanding the views of the SRSP, the draft CS has met with controversy. Two of the controversies that have arisen will be considered here in detail.

⁴ 'Health is a state of physical, mental and social well-being, and not merely the absence of disease or infirmity' (WHO). The *World Health Report 2001* about mental healthcare repeats that mental health care is more than the absence of a psychiatric clinical picture. However, a closer description is not ventured, since this would be hardly feasible from a transcultural point of view. Subsequently they focus on factors that influence (mental) healthcare [21].

E.3 CONTROVERSY I: RELIGION AND SPIRITUALITY

The draft CS opens with the observation that religion and spirituality, although neglected for a long time, are increasingly recognized as being of relevance to the examination and treatment of patients, and also to the understanding of psychiatric disorders. This immediately invites debate concerning the proper definition of religion and spirituality. The draft CS offers a simple explanation of each of these terms but does not (by virtue of its brevity) engage with the huge literature debating how these terms should best be defined. The definition offered for spirituality is based on that proposed by Cook [24]. A definition for religion is not offered, as such, but the scope of traditionally employed definitions is briefly described. (In drafting the CS, CCHC had in mind the discussion provided by Bowker [25, pp xv–xxiv]).

Even more problematic is the relationship between religion and spirituality, and this has proved to be important in relation to the international debate about the CS so far. A number of participants in this debate would rather see the concept of religion removed entirely in order to deal with spirituality alone.⁵ However, it is an issue which is also elaborately discussed in *Geloven in het publieke domein* [18]. In this interesting study by the Scientific Council for Government Policy (in Dutch: *Wetenschappelijke Raad voor het Regeringsbeleid (WRR)*) lots of studies and material can be found that all relate to the ‘return’ and transformation of religion in its relationship to spirituality. According to this point of view, the term spirituality is not merely inclusive of religion, but rather supercedes it.

E.3.1 Spirituality

There are multitudinous definitions of spirituality, arguably corresponding to each other in certain main points. The possibility of reaching a consensus would therefore seem to be a reasonable one. Recurring themes include the capacity for relationality and spirituality as a defining characteristic of being human. The general idea seems to be that spirituality implies a developed form of relationship to oneself, the other and the transcendent. This understanding of the transcendent is often but not exclusively an ‘inner-worldly’ one. Formulated in this way the transcendent is not primarily a capacity, but a form of relationality. How someone develops spiritually is just as unique and personal as the way someone develops with regard to personality.

What does this concept of spirituality aim to achieve then? It is a quest ‘for attaining an optimal relationship between what one truly is and everything that is’ (Van Ness, quoted by

⁵ It is important to note here that the text was drafted by CCHC with help from members of the SIG Executive Committee. It therefore represents the views of that group. The approach taken by the SIG is outlined in a patient brochure entitled: *Spirituality and Mental Health* (www.rcpsych.ac.uk). The text makes clear that spirituality is indeed seen as the more comprehensive concept, inclusive of, but not confined to, that of religion. Spirituality is described as being universal and at the same time uniquely personal. Religion usually presupposes communal worship, along with beliefs and other sacred traditions. In Koenig’s editorial ([6], see above), it might be noted in passing that the concepts seem to blend rather differently. The title is: *Religion and mental health*. He speaks about taking a ‘spiritual history’, but subsequently talks about ‘religious background’, and ‘religious beliefs and practices’. Josephson and Wieser [26] introduce the even wider idea that religion and spirituality comprise the concept of a ‘world view, or philosophical outlook on life’ and in this way want to make the term inclusive of all ideologies, religious, spiritual or other.

Schneiders [27, p. 166]). It concerns how the self as a whole relates to the cosmos as a whole. The advantage of such a definition is evident in its inclusiveness of both religious and secular forms of spirituality. More specific, but no less inclusive is the following definition of spirituality: ‘the experience of conscious involvement in the project of life-integration through self-transcendence toward the ultimate value one perceives’ [27]. These definitions are very consonant with the draft CS formulation. There are also similarities with Cloninger’s capacity of self transcendence and (expression of) spirituality [28]. By contrast, other definitions see spirituality as something at the heart of philosophy or religion [29], almost inverting the relationship proposed here between spirituality and religion.

However, any direct reference to religion has disappeared from the definitions of Van Ness and Schneiders. Spirituality comprises an awareness, an experience of something that surpasses ordinary observation and perception. It is not simply an abstract idea, or theory. It includes an element of advancing movement, a quest. It is not a once-only experience or event. It contains an element of integration, unification and, consequently, unity. Spirituality is holistically oriented. Looking at specific (e.g. religious) spiritual traditions from that point of view, similarities can naturally be observed between them.

E.3.2 Religion

The concept of religion as we now employ it, namely as a term trying to denote the communality of all religions, dates back to the seventeenth century [18, p. 38]. Modern definitions of religion usually distinguish between essential and functional approaches. In the first approach one seeks to denote the core essence of religion. In the second approach the function of religion is formulated. The latter is perhaps more frequently encountered in research into religion and mental healthcare. The approach of looking for the evolutionary origin of religion also fits into the functional framework. The interesting feature of this approach is a reversal of the more or less usual argument, dictated by our ‘traditional’ thinking, which proceeds from the basis of there being one ‘true’ religion. Instead, diversity in religion is seen not as the result of diversification from a (presupposed) original religious unity, but a reduction of a (possibly infinite) multitude of religious ideas that occur in the human mind, and from which the most useful or functional remain and are passed on [30, 31].

Essentialist religion can be denoted as a fundamental attitude to life in relation to a transcendental reality (with or without God or gods), a dependence on the source of life accompanied by awe and gratitude, a desire to live in harmony with that, and transcendental faith in life and death [27, p. 168]. Thus formulated, religion also includes a number of spiritual traditions, for example Christian or Buddhist, even when people have turned away from organized religion. But religion also represents an institution, alongside other institutions in society. Religion as an institution recognizes official bearers of the institution, with its codes and practices.

However, religion is not always visibly institutional. In some cultures it is entirely interwoven with daily life, and is not a social institution in the usually accepted sense, as for example in Japan (see below). It can also be formulated differently. Religion, as in the Judeo-Christian tradition, represents a type of culture in which certain beliefs or values are shared. But there is almost always some tension between religion as a living tradition and religion as an institution. Schneiders points out that institutionalization presents a great danger to authentic tradition. It potentially takes the place of that tradition, and its values,

leaving a hollow shell, associated with empty ritualism, abuses of power, hypocrisy and other unattractive remnants. But Schneiders also warns that beheading is not the best cure for a headache [27, pp. 171–172].

The concept of religion as now employed in the West presupposes a partition of domains, between the profane and the sacred. In other cultures such a dichotomy does not occur at all, as we will see below.

E.3.3 Spirituality and religion: the relationship

How do religion and spirituality relate to each other? Schneiders [27] suggests three possibilities:

1. *Religion and spirituality regarded as two completely separate domains that have no connection.* Obviously, one can be spiritual without being religious, although the arguable possibility of religion without spirituality is a little more controversial. (Is not all religion associated with some kind of spirituality, even if it is unattractive or apparently 'empty'?). Spirituality might be perceived as the more personal domain, and religion the more social.
2. *Religion and spirituality seen as rivals.* According to this view, there are not two domains, but *one* domain where spirituality and religion are each fishing in the same metaphorical pond. Here we may either turn towards spirituality, as preferable to an empty, or meaningless, religion, or we may turn towards religion, in preference to a 'disorderly' spirituality that will not conform to institutional authority.
3. *Religion and spirituality considered as two dimensions of the same quest, in a sometimes tense, yet mutually indispensable relationship with each other, but nonetheless sharing the same fundamental concerns.* According to this view, religion and spirituality are partners.

What might make (personal) spirituality appear more meaningful than (institutional) religion? Schneiders [27] suggests three factors. Firstly, religion(s) traditionally claim exclusivity. That exclusivity can be cultural, geographical and tribal, but also doctrinal ('outside the church there is no salvation'). Some would argue that this is what has led to religious persecution, hatred and war. Secondly, and closely linked to this theme of exclusivity, is the ideological aspect of religion. If one belongs to the church, one commits oneself to its rules and practices. This could suggest a certain oppressiveness and constraint, and may be why many people rebel against aspects of doctrine and religious practices. Thirdly, there is the clerical factor. This does not relate to clergy who, for example, are engaged in meaningful work in worship or pastoral care, but rather to authority that is based on pretence rather than competence.

Schneiders [27] pleads for a partnership of spirituality and religion in which religion provides the encompassing framework for spirituality, rather than the other way round. Her Roman Catholic background is presumably conducive to this view, but she is not alone.⁶ In

⁶ Van Praag, in his latest Dutch book, is remarkably critical towards the concept of spirituality. He calls it 'vague' and characterizes spirituality as a 'leaning towards the higher'. Religion, on the other hand, has a distinct focus, a foundation and a bedding. 'To the religiously susceptible man God is *the* symbol of spirituality. All other manifestations of spirituality are by definition of a *lower* order' ([35, pp. 24–25]; curs. PJV).

contrast, as we saw earlier, others take spirituality as the encompassing concept. But, if we assume for a moment that partnership of some kind will be essential to take forward something such as a CS on spirituality and religion in psychiatry, how may we deal with inter-religious, inter-spiritual dialogue in our own countries and worldwide, given that there is such religious and spiritual plurality? What might partnership look like within the doctor-patient relationship? Do we require a completely new type of spirituality?

Schmidt-Leukel [32] who became intensively involved in the dialogue between Christianity and Buddhism, outlines such a new 'inter-faith' spirituality, based on seven virtues: confidence, humility, curiosity, friendship, honesty, courage, and gratefulness. Confidence (or faith) acknowledges a transcendent (yet also immanent) order that is of decisive importance to our understanding of reality and especially our relationships with our neighbors. Humility puts aside exclusivity claims. The Infinite surpasses our thinking and feeling so much that our understanding is acknowledged as being only partial. Yet the transcendent is also a part of the religious experience, and that makes us curious, and this curiosity or wonder might initiate dialogue. That brings about a different attitude towards one another: friendship, says Schmidt-Leukel. How else can we exchange and share each other's beliefs? Such a friendship presupposes honesty which is not uncritical, but with the opportunity of 'brotherly admonishment'. Courage and gratefulness complete this set of seven virtues that characterize 'inter-faith' spirituality.

Is Schmidt-Leukel being over-idealistic, or even completely unrealistic? There is considerable criticism against this 'dialogue-ideology', not least from the side of secular liberalism [33]. However, we might note the theses that Hans Küng once formulated: no world peace without religious peace, no religious peace without religious dialogue, no religious dialogue without research into the foundations of religion [34].

E.4 CONTROVERSY II: TAKING A SPIRITUAL HISTORY?

In two places in the draft CS the word 'essential' is used: religion and spirituality are said to be an 'essential' component of the spiritual history, and, knowledge of religion and spirituality are said to be an 'essential' part of psychiatric training. The use of this word, especially in the former context, appears to have been unacceptable to some participants in the international debate on the CS. What are the objections?

From the perspective of Japanese Buddhism, it is said that it is totally unconventional for a psychiatrist to ask a patient about his or her religious beliefs. The question is either too private, or else not important enough to the immediate purpose in hand (ie psychiatric assessment and treatment). A doctor would only ask such a question, it has been argued, in such extreme circumstances as might apply, for example, in the case of terminal illness. Considerations here are that religion is understood as a part of daily life and not an ideological conviction. If the patient were to be asked about his or her religious beliefs, the most likely answer would be that he or she does not have any. Here, it would appear, the concept of religion as we know it and handle it in general international parlance (or perhaps merely in Western culture?) does not work for the purpose at hand. There is evidently no universally accepted phenomenon called religion [18, p. 38].

Of an entirely different order is the objection on the part of some psychiatrists from the former Soviet republics. There it is also said that a psychiatrist would not easily ask questions about religion. Here, the concern is that it would be too politically charged and far

too risky. After all, not so long ago religion was not only scorned but was even politically prohibited. Therefore to talk about religion in a clinical consultation could be perceived as having potentially disagreeable political consequences and should not be done.

These objections are interestingly paralleled within psychiatry in the United Kingdom. Amongst the objections to Koenig's editorial [6] raised by Poole et al. [9], was an assertion that psychiatrists are 'essentially applied biopsychosocial scientists, who work within a clear set of humanitarian values and ethical principles in order to get alongside service users and facilitate their recovery from a mental illness'. In this context, dabbling in matters of spirituality and religion is seen as breaking 'the boundaries of our legitimate expertise'. This would appear similar to objections raised by Japanese psychiatrists concerning what is within the rightful domain of psychiatric enquiry. The implication may also be that spirituality and religion are either too private, or else not important enough, to be relevant to the role of the psychiatrist. Poole et al. [9] refer also to the dangers of 'religious breaches of therapeutic boundaries' which, although not of a political nature, would appear similar to the dangers perceived by Eastern European psychiatrists who fear that asking questions about religion may present a potential threat to the therapeutic relationship.

These and other objections are understandable, but at the same time they are curious, given 'state of the art' transcultural psychiatric research. In the second version of the *Practice Guideline for the Psychiatric Evaluation of Adults* [36] it is argued that in the framework of the social and cultural history of the patient, cultural and religious influences should be considered both in terms of meaningfulness and goals in life, and in terms of sources of support or even stress. Attention to these influences plays a crucial role in developing a treatment relationship, coming to a treatment plan in terms of treatment goals and outcome measurements, and promoting therapy loyalty. To give such factors adequate consideration requires a respectful, empathic, non-judgmental attitude. Thus it is necessary to acquire awareness of one's own prejudices, 'biases', and limitations with regard to expertise and related skills. This means that formulating a case and treatment contract requires much more than simply making a diagnosis. It requires careful consideration of social and cultural factors, including religious and spiritual beliefs.

The transcultural perspective has thus become a fundamental framework for psychiatric practice, at least since the introduction of DSM-IV [37]. It comprises five aspects: the individual's cultural identity, culturally determined ideas about disease, cultural factors related to the psychosocial environment, cultural influences on the doctor-patient relationship, and cultural influences on diagnostics and care. These five aspects always contain religious and spiritual elements.⁷ Viewed from this perspective, Asiatic and Eastern European objections to the CS come under the heading of cultural influences on diagnostic and therapeutic processes. They clearly need to be recognized as such. At the same time it has become clear that the concept of religion is itself a culturally sensitive construct.

It is transculturally curious that certain subjects of enquiry (spirituality and religion) might be considered 'off limits' when taking a history. It is also curious that within any

⁷ It should be noted that the American guideline(s) do not necessarily have the final word. On the other hand, they are very influential. Similarly, American and British educational requirements have been very influential in psychiatry (see a recent special issue of *International Psychiatry*, April 2007). The American curriculum explicitly promotes attention to knowledge and skills with respect to religion and/or spirituality. The British curriculum, currently under revision, has long promoted attention to issues of culture, but (until recently) not specifically spirituality or religion. Proposals are under consideration for spirituality and religion to be integrated explicitly and fully into the new curriculum.

culture a clinical speciality which legitimately enquires after the most intimate aspects of patients' lives, in order to build a better bio-psycho-social understanding of their condition, might actually consider some matters too sensitive to discuss. If spirituality (or sex, or politics, or anything else) actually is too private, or else too unimportant, for discussion, where does this leave us?

Firstly, we hope that the foregoing discussion has shown that spirituality and religion are in fact not unimportant to psychiatry. Research suggests that there are evidence based reasons for including spirituality and religion in the assessment process and in treatment planning. In any case if, as Poole et al. [9] argue, there are significant dangers surrounding inclusion of spirituality and religion in clinical history taking, the matter cannot also be unimportant. The reasons for not including this topic within clinical history taking must be based on some other grounds.

It might be implied that there are issues which are so important to our patients that it is difficult to talk about them without fear of misunderstanding. However, this may be revealing of politically or culturally imposed barriers that have undermined the spirit of openness and trust which is fundamental to therapeutic relationships. Ignoring these barriers, let alone deliberately preserving them, is surely not in our patients' best interests. It will surely reinforce both social conventions, and professional ignorance, which create a fear of discussing things that risk misunderstanding. Yet this is no different from many areas of clinical enquiry in which the patient is the expert from whom the clinician must learn. As Koenig points out [6], there are also clergy, chaplains and others whose help may be sought in support of this learning process.

The important objections raised within the United Kingdom, Eastern Europe and Asia raise equally important questions about the nature of the therapeutic relationship, and how this may be restricted by cultural perceptions of particular subjects (such as spirituality and religion) which are felt to be 'off limits'. But surely these perceptions, and their validity or lack of validity, must be a legitimate subject for professional and academic conversation within psychiatry? Or are they to remain unexamined secrets – something which psychotherapy has so often shown to be a cause of psychopathology?

E.5 FINDING A WAY FORWARD

The controversies encountered during the course of the debate on the CS became so heated that the WPA Executive Committee decided that it was impossible to introduce the CS proposal at the meeting of its General Assembly (the highest organ of decision making within the WPA), during the most recently held WPA world conference in Prague, 20–25 September 2008. The CS has therefore not yet been included in the list of CSs, to be submitted to WPA members for consultation. On the other hand, consultation within the SRSP yielded satisfactory interest and support. An impasse has thus been reached, and there would not appear to be an easy solution. Presently (March 2009), consideration is being given to the possibility of the draft CS being adopted as a position statement, rather than a consensus statement, since the WPA procedures for this are less rigorous. However, it would seem very unsatisfactory that such an important topic should appear to be reduced in significance in this way.

We dare to hope that a solution might yet be found in the very process for which the CS was first drafted: that of encouraging international dialogue. Understanding between

psychiatrists of different culture, spirituality and faith tradition may be every bit as sensitive as that between any psychiatrist and patient. It requires mutual respect, patience, empathy and a desire to understand the other better. But this is, in itself, a spiritual task – not unlike that defined within the new spirituality of Schmidt-Leukel's seven virtues.

We therefore continue to seek agreement, acknowledging respectfully that we need fully to acknowledge the perspective of Eastern European, Asian and other colleagues if we are to achieve anything worthwhile. This process has certainly instilled in us a curiosity as to how our understanding of psychiatric assessment can apparently differ so significantly according to cultural context. We hope that this curiosity will carry us forward, with colleagues from other disciplines (especially anthropology, theology and the study of religions), to a better understanding of what lies beneath our different views of spirituality and religion and their relationship to psychiatric practice. We have confidence also in the international friendships that our common vocation to psychiatry has established and, through these friendships, we hope to pursue honestly and courageously the possibility of an agreement that will transcend our differences. Finally, we are grateful to all colleagues who continue working with us towards this end when their personal convictions oblige them to disagree with us.

Are we, like Schmidt-Leukel, being over-idealistic and unrealistic? Perhaps we are, but we think that the benefits of succeeding, and the costs of failing to try, are so great that we must persevere in our efforts to find the way forwards.

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PROPOSAL

Revised proposal for a WPA consensus statement on spirituality and religion in psychiatry

Whereas spirituality and religion have often been neglected in clinical and academic psychiatry, they are increasingly recognized as being of importance in the understanding of psychiatric disorders, and in the clinical assessment and treatment of patients. Both terms lack a universally agreed definition.

Spirituality is a distinctive, potentially creative, and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately 'inner', immanent and personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth, and values.

Religion is usually defined more in terms of systems of beliefs and practices related to the sacred or divine, and definitions often refer to social institutions and communities within which such systems are agreed and held in common. However, the scope and variability of such definitions is enormous, with some people identifying spirituality and religion as virtually synonymous, or at least as overlapping concepts, whilst others see them as contrasting or opposed categories. Others would see religion as much more individual than social, and yet others would focus less on religion as being concerned with belief systems and more on its concerns with morality, praxis or faith.

In many Western countries, both religion and spirituality are now often faced with the context of a secular society, in which most public discourse is conducted without reference to either religion or spirituality. In many other parts of the world religious tradition continues to provide a shared frame of reference for public life and discourse. Faith communities, and spiritual or religious practices, have the potential to influence the course of mental illness, and attitudes towards people suffering from mental illness, for good or ill.

Whatever disagreements there might be on definition, spirituality and religion are concerned with the core beliefs, values and experiences of human beings. A consideration of their relevance to the origins, understanding and treatment of psychiatric disorders should therefore be a central part of clinical and academic psychiatry. Spiritual and religious considerations also have important ethical implications for the clinical practice of psychiatry. In particular, it is affirmed here that:

1. Spiritual well-being is an important aspect of health.
2. Empirical evidence reveals a largely positive relationship between religiosity/spirituality and different indices of health. However, religious and spiritual beliefs are powerful forces and may impart harmful as well as beneficial effects.
3. A tactful consideration of patients' religious beliefs and spirituality should be considered as an essential component of psychiatric history taking.
4. An understanding of religion and spirituality and their relationship to the diagnosis, aetiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development.

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5. There is a need for more research on both religion and spirituality in psychiatry.
 6. Psychiatrists should be expected always to respect and be sensitive to the spiritual/religious beliefs and practices of their patients, and of the families and carers of their patients, and not to use their professional position for proselytizing or undermining faith.
 7. Psychiatrists, whatever their personal beliefs, should be willing to work with leaders/members of faith communities, chaplains and pastoral workers in support of the well-being of their patients, and should encourage all colleagues in mental health work to do likewise.
 8. Psychiatrists should demonstrate awareness, respect and sensitivity to the important part that spirituality and religion play for many staff and volunteers in forming a vocation to work in the field of mental healthcare.
 9. Psychiatrists should, whenever appropriate, work for a better understanding between colleagues and patients of different religions and cultures, bearing in mind that social harmony contributes to mental health and well-being.

World Psychiatric Association Section on Religion, Spirituality and Psychiatry

Executive Committee of the Spirituality Interest Group (SIG),
Royal College of Psychiatrists

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