

SECOND DRAFT

Religion, Spirituality and Psychiatry: Crossing the Boundaries.

A Statement prepared by the WPA Section on Religion, Spirituality and Psychiatry.

Introduction

In the last decade, the clinical and research boundaries between religion, spirituality and psychiatry are being explored with renewed vigour. Recent advances in the brain science of the spirit (Fenwick, 2009), the greater influence of continental existential philosophy (Matthews, 2007), and the demand from user groups for a whole-person health service have facilitated these boundary crossings.

Globalisation, forced migration of political or economic refugees (Carta et al, 2005), increased awareness of the mental health causes and consequences of mass violence (Cox and Ghodse, 2007), the greater public health interest in 'Wellbeing', the search for 'meaning' and for a multi-faith religious philosophy of compassion (Armstrong, 2001; King, 2009), are other strands to consider.

This new situation is particularly challenging, however, for psychiatrists and other mental health professionals, especially in post-modern 'Western' countries. After the closure of asylums with their conspicuous religious buildings, there has been a tendency to neglect the religious dimension and existential components of health care. Many doctors across the world instead have embraced a biomedical model of mental disorder and tended to devalue the art of medicine, the wisdom of the experienced clinician, as well as the therapy of a professional relationship (Montgomery, 2006).

It is within this challenging global situation that the World Psychiatric Association has decided to develop this Position Statement on Religion, Spirituality and Psychiatry, prepared by the WPA Religion, Spirituality and Psychiatry Scientific Section.

International Perspectives

The World Health Organisation (WHO) had previously considered the inclusion of spiritual well-being in its definition of Health; but spirituality, existential well-being and religion has remained as a core domain of the WHO Quality of Life measures. The WHOQUOL-SRPB group (2006) recommended for example that greater attention to this domain will improve quality of life, particularly for those who report poor health or are at the end of their life.

The World Psychiatric Association (WPA) undergraduate and postgraduate curricula each included religion as a component of a contextual psychiatric assessment; and the WPA has also published International Guidelines for Diagnostic Assessment (IGDA), which articulated an integrative approach to assessment by combining descriptive and narrative methods (Mezzich et al, 2003). More recently, however,

Musalek (2010) published in the WPA Bulletin a useful account of a Humanistic based medicine, which is closer to that advocated by Family Practitioners, such as Tournier (1986), and to Carl Rogers' Person-Centered therapy. Okasha (1999) in a plenary lecture delivered at the XIth World Congress of Psychiatry in Hamburg had cogently pointed out the complexity of these tasks by emphasising that religion contained so many unrelated variables that it cannot be considered as a uni- dimensional concept. A proposition illustrated by reference to both traditional (Islamic) and Western societies.

From an African perspective Van Staden (2006) emphasised the primacy of the person in psychiatry, and regarded the biological, social and psychological sciences as 'extricates'; Psychiatrists in East Africa (Sorketti et al, 2010) and South Asia (Bhugra, 2007) take for granted this humanistic need to understand the religious and spiritual perspectives for effective work in the mental health field. In more secular individualistic countries, however, such as Sweden (De Marinis, 2003), inquiry about traditional or contemporary religious beliefs in a psychiatric assessment is commonly regarded as inappropriate, and as a possible intrusion of privacy.

Fulford et al (2010) has popularised Values-Based Medicine (VBM) as a pillar, together with factual scientific evidence, of sound medical practice. They regard religious and spiritual values as being a distinct value category that health care practitioners need to consider.

The Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group has recently published a multi-author book 'Spirituality and Psychiatry' (Cook, Powell and Sims, 2009) with chapters on suicide, psychosis and the assessment of spiritual needs, whilst Dein (2010) has included informative case histories of patients with religious delusions and possession states.

There are similarly active professional and User groups in the Netherlands, and particularly in the US where much research in this field is currently being carried out. The International Journal of Mental Health, Religion and Culture regularly publishes scientific research in this field, and more recently the Journal of the Evaluation of Clinical Practice has articulated a conceptual challenge to a narrow reductionism in medicine and reliance on Evidence Based Medicine alone (Miles, 2009).

Definitions

Religion can be defined as systems of beliefs and practice related to the understanding of the Sacred and the Divine which are expressed in social institutions and communities. Spirituality, on the other hand, is a more universal dimension of human experience, which may be separate from religious practice and is often concerned with existential individual issues of meaning and purpose, and may relate also to a personal understanding of the Numinous.

Since religious belief and spiritual practice are both concerned with core beliefs, values and sense of self, an understanding of these dimensions is important to the practice of much clinical psychiatry.

What are the mediating factors between Religion and Mental Disorder?

The pathways to explaining these connections and to facilitating boundary crossings between psychiatric practice and religious beliefs can be considered with reference to factors that are **common** to religion and mental disorder (e.g. genetic, biological, developmental, personality), and **mediating** factors, such as hope, compassion, confession and food prohibitions (Verhagen and Cox, 2010).

There is evidence of a beneficial effect of Spirituality / Religion on Mental Health (Koenig et al., 2012) but also evidence of a harmful effect (Crowley and Jenkinson, 2009) and there is a need for further epidemiological studies in all regions of the world.

Recommendations

With these considerations in mind, psychiatrists, and their professional organisations, are urged to implement the following recommendations:

- Increase the understanding of the contribution of religion and spirituality to the causes and management of mental well-being and mental disorder.
- Include spiritual wellbeing, existential (non-religious) meaning and religious belief in measures of Quality of Life.
- Encourage health professionals to recognise the importance of religious beliefs and practices and spirituality for ethnic minorities and migrants from various religious countries and cultures.
- Be aware of the influence of the doctor's 'world view' on the provision of inclusive mental health services.
- Work with leaders of faith communities, spiritual advisers and hospital chaplains to enhance the provision of person centered care and to address religious and spiritual issues; proffer training.
- Routinely include a sensitive assessment of his or her religious beliefs and spiritual practices according to the patient's needs as they may affect diagnosis, the provision of care and recovery strategies.
- Respect and be sensitive to all beliefs of the patients and their families, never denigrate them, unless strong evidence points out that such beliefs are harmful to the patient and there for clinical attention is needed.
- Never impose your own beliefs on patients or attempt to proselytize.
- Respect the religious and spiritual motivation of mental health workers without devaluating their values.

- Provide supervision and respectful dialogue to health service personnel whose religious understandings and religious beliefs have a negative impact on their wellbeing or on the wellbeing and religious beliefs of patients.
- Develop CME programs and clinical audits in the field of psychiatry and religion.
- Undertake research on the clinical outcomes (positive and negative) of the effects of the recommendations described in this statement.

Key books recently published - which each include comprehensive references to scientific publications in this field:

Verhagen, P.J., van Praag, H.M., Lopez-Ibor, J.J., Cox, J.L., Moussaoui, D. (eds.) (2010). *Religion and Psychiatry: Beyond Boundaries*. Chichester: Wiley-Blackwell.

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This Position Statement was first drafted by Peter J. Verhagen MD, prof. John Cox and prof. Chris Cook, then reviewed by other members of the old (prof. Herman van Praag; prof. Driss Moussaoui) and new (prof. Nahla Nagy) Executive of the WPA Section on Religion, Spirituality and Psychiatry (2010).