What do spirituality and religion have to do with psychiatry? Study of the programme for the 2015 International Congress of the Royal College of Psychiatrists (RCPsych) might suggest that the answer is ‘Not very much!’ Perhaps this will seem completely appropriate to many psychiatrists, but I’m left wondering why an RCPsych Congress programme should include so little about spirituality and religion. Or, to put the question more positively, are there reasons why such a conference programme should include more reference to spirituality/religion than this one did?

I should start by declaring that I am an Anglican priest as well as a psychiatrist, and that I work (rather unusually for a member of the RCPsych) in a university department of theology and religion. I am president of the British Association for the Study of Spirituality, and at Durham University I am director of a MA/MSc programme in Spirituality, Theology & Health. I’m a past Chair of the Spirituality and Psychiatry Special Interest Group (SPSIG) at the RCPsych. So, I might be perceived by some as having a ‘conflict of interests’ concerning spirituality and psychiatry, although I prefer to call it a vocational interest.

I should also say at the outset that the 2015 RCPsych Congress programme, apart from its lack of attention to spirituality and religion, was everything that a good international conference on psychiatry should be. I attended the whole conference this year, and I came away better informed about progress in psychiatric research, and impressed by the dedication and commitment of colleagues to pursuing high standards in clinical practice. The conference was addressed by a government minister, and the chief executive of NHS England, both of whom expressed their commitment to providing the best possible mental health services in a time of austerity, as well as by the College president and other leading researchers and clinicians. But, insofar as programme content was concerned, spirituality and religion were largely ignored. Presumably, therefore, they are seen as irrelevant, or at best peripheral, to the important political, clinical and academic issues that confront psychiatry today.

The only session title in the programme specifically addressed to spirituality or religion was concerned with possible violation of the boundaries of good psychiatric practice. Although I was obviously not personally able to attend every other session in the programme (this would be impossible with six or more sessions running in parallel for much of the time) there were only infrequent, and sometimes negative, references to these topics elsewhere, even where they might have been thought to be clearly relevant. Thus, a session on ‘old and new approaches to the management of depression’ gave no attention to mindfulness, a session on the function of delusions
suggested that delusional belief might be similar to religious belief, and a session on terrorism – almost exclusively drawing on recent examples of Islamist terrorism - gave no attention to the relationship of radical or fundamentalist belief to mainstream religious tradition.

The workshop on ‘Violations of professional boundaries related to religion and spirituality’ was actually very well attended and generated a constructive debate, which suggested that psychiatrists actually do want to explore these topics critically and thoughtfully. The workshop was proposed and led by Professor Rob Poole, well known for his concerns about the potential for boundary violations in this domain (Poole and Higgo, 2011), and his colleague Professor Catherine Robinson. I was invited as a delegate to participate and am pleased to be involved in an ongoing research collaboration with Professor Poole and Professor Robinson, which aims to clarify the boundary issues, involved. Within the workshop three clinical vignettes, all based on real life cases, were explored in some detail and positive as well as negative aspects of addressing spirituality/religion in clinical practice were discussed. The seriousness of the concerns raised, and the level of engagement by delegates, suggested that this was an important topic for clinicians and for patients.

The now vast research literature on spirituality and religion in relation to mental health, as surveyed for example in Harold Koenig’s encyclopaedic review of research studies, the *Handbook of Religion and Health* (Koenig et al., 2001, Koenig et al., 2012), is generally interpreted as showing that spirituality and religion have a very positive influence on morbidity, mortality and treatment outcomes. Whilst the evaluation and interpretation of these studies has been questioned, the sheer volume of research might suggest that this is something that psychiatrists should be informed about, as indeed the College recommends in its own position statement, *Recommendations for Psychiatrists on Spirituality and Religion* (Cook, 2013). Perhaps more importantly, this is something that service users have indicated they would like to see addressed as a part of their care – or, at least, that they would like to be able to talk to their psychiatrist (or other mental health professional) about it when relevant without fear of censure and without fear that it will simply be labelled as a part of their psychopathology.

So, why the absence of attention to spirituality and religion in an International Congress of the RCPsych in 2015? It seems to me that there are several possible reasons for this, all of which deserve closer scrutiny.

**Why might spirituality/religion not be included in an RCPsych International Congress programme?**

The first possibility is that most psychiatrists are actually not interested in this topic, and would prefer not to see it included in the programme. This view would appear to be invalidated by good attendance at the one workshop on the topic on offer this year, but if only 80 psychiatrists amongst many hundreds of delegates are interested, then
perhaps this is a minority interest and not worthy of much attention in the wider programme?

As far as I can see, there is no quantitative, empirical, evidence to support this contention. The Spirituality and Psychiatry Special Interest Group is one of the larger College SIGs, with approximately 3000 members, and one of the most active, having held two or more day conferences at the College each year since its inception in 1999. Amongst its other activities, it has produced an edited volume, *Spirituality and Psychiatry* (Cook et al., 2009), published by RCPsych Press, which continues to sell well 6 years after publication. Staff at the College bookstall in the conference exhibition hall told me that they had to request a delivery of extra copies during the conference, as their initial stock had sold out. College journals have also, in recent years, included vigorous correspondence on the topic of spirituality and psychiatric practice.

Even if most psychiatrists are not interested in spirituality or religion (which is clearly very debatable), if patients find these topics important, it might well be argued that they should be included more prominently in the Congress programme anyway. After all, psychiatrists are not paid simply to give attention to what interests them, but rather to give attention to all matters that are important and relevant to the better understanding of mental disorders and mental wellbeing and to the good clinical care of their patients. This line of thought leads us to the second possible reason why spirituality/religion are in fact not included more prominently or more positively in the Congress programme. That is, although these matters might be thought of as important by patients, perhaps psychiatrists don’t agree with their patients. Is there a general perception amongst psychiatrists that these matters are not only not interesting, but also really not very important?

This possibility would initially seem to be quite plausible. Notwithstanding Koenig’s positive review of the research literature, there has been a robust critique suggesting that the strength of the relationship between mental wellbeing and spirituality/religion has been exaggerated, that findings largely based on US research might not apply in other parts of the world, that the methodology of much early research was poor, and that in any case it isn’t terribly important in practice since we couldn’t legitimately tell people to change their religious beliefs and behaviours simply in order to gain health benefits (Sloan et al., 1999, Sloan, 2006). However, on close scrutiny I think that this possibility appears less plausible. Even if there were doubt about the strength of the research evidence, the scientific critique of a now enormous body of research evidence that is claimed by some to offer large benefits would seem to be a legitimate and appropriate focus of critical attention at an RCPsych Congress. More importantly, the relevance of spirituality/religion to psychiatry does not rest on this research evidence alone. Indeed, if research showed that spirituality/religion were *bad* for mental health that would also be a reason for attending to these matters. Only if they are completely irrelevant would it appear to be legitimate completely to neglect them, and this would seem to be very unlikely.

A third possibility is that psychiatrists actively do not wish to address this topic as they perceive it as dangerous and harmful, either to their patients, or else to their own
professional standing. This also may be a cogent argument and the series of high profile cases reported in the UK media (albeit mostly not relating to psychiatrists) in which health professionals have been suspended or have faced disciplinary action for allegedly breaching the boundaries of good professional practice in relation to religion would lend weight to the genuineness of this concern. The dangers of bad practice are given due weight in the Royal College position statement, *Recommendations for Psychiatrists on Spirituality and Religion*. The title of the previously mentioned workshop at the 2015 Congress, referring as it does to violations of professional boundaries, may have been popular precisely because of this kind of concern. But this again suggests that it is something that should be more widely debated rather than ignored. Does a profession which tends to be less religious than its patients (Cook, 2011) actually prefer to ignore the topic, whilst quietly believing (after Richard Dawkins) that everyone would be better off without religion? Psychiatrists are a more heterogeneous group than this question might imply, and it seems implausible to me that the many religious members of the College would subscribe to this, even if a significant number of atheists or agnostics might.

A variation of this argument is that psychiatry is actually best practiced in a secular domain and that this provides a safe neutral space within which people of different faiths and no faith can come together to address matters of common concern relating to mental health (Poole and Higgo, 2011). Unfortunately, secular space is not perceived as either neutral or safe by many religious people (Cook et al., 2011). This position also rules out, a priori, any possibility that spirituality or religion might have important things to say to inform the practice of psychiatry. There is no ‘view from nowhere’, and secularity has its own biases and preconceptions, just as do the perspectives of spirituality or religious tradition. The danger is that clinicians and researchers who adopt the secular perspective presume to be objective, and are thus blind to the biases and prejudices inherent within it.

A fourth possibility is that this is something that many psychiatrists would like to see addressed - and that there are good reasons why it should be addressed in an RCPsych Congress programme - but that there are selection factors which ensure that proposals concerning spirituality/religion do not actually make it into the conference programme. Perhaps the methodological criticisms of the wider literature on spirituality/religion also apply to the submissions received by the conference organisers, and so they are excluded on basis of merit? Perhaps it is simply the case that few submissions on this topic are received. (I do know that at least one submission, from the Spirituality & Psychiatry SIG, was not accepted, but perhaps this was the only one?) There was a strong profile of biological psychiatry within the programme and perhaps submissions on spirituality/religion are not perceived to compare favourably with material that is more scientific (especially when the conference theme, as in 2015, is concerned with psychiatry ‘at the forefront of science’)? Perhaps the conference organisers have their own reasons for not wanting such material to be included. None of these possibilities seem very compelling or valid to me, but they are all potentially remediable. Good quality proposals for conference sessions on spirituality/religion can and should be submitted by College members, and they should be assessed on their merits. There presumably could also be a process
whereby such submissions and their successes/failures to make it into the programme might be monitored and reviewed?

I wonder whether one of the selection factors that might operate against inclusion of religion and spirituality in an RCPsych Congress programme is that psychiatry has a particular history as a profession, and a particular epistemological context as a scientific discipline, neither of which are particularly conducive to religion. Psychiatry as a discipline has arisen in a post-enlightenment frame of reference that does not see theology or religion as having constructive contributions to make to scientific or public discourse. As Professor Poole (2008) has suggested, psychiatry might be seen as an applied science, and religion (and by the same token spirituality) might therefore be construed as non-scientific and at best irrelevant, or at worst deleterious to clear thinking about mental health and mental disorder. Indeed, Freud has not been alone is suggesting that religion might in fact be a reflection of mental disorder rather than of human flourishing. All of this fails to take into account the way in which the world has changed in recent years. Religion has re-emerged as a major topic of debate, both in public affairs and in academic endeavour. Has psychiatry not kept up? Is it merely stuck in a rut and continuing not to engage with religion out of habit, or else out of an inflexible and blinkered tradition of not talking about such things, or only doing so negatively?

**Common Interests**

One of the profound impressions made on me by the 2015 Congress was that psychiatrists are interested in, and concerned about, many of the same things as theologians, chaplains, religious leaders, and ordinary religious people around the world, not to mention the increasing number of those who identify themselves as ‘spiritual but not religious’.

People struggle to understand and interpret unusual or troubling human experiences, especially when these experiences are associated with things that they value most, or which are otherwise strongly affectively laden. They struggle to understand their own behaviour at times (perhaps often), let alone the behaviour of people around them, and not least when inhuman atrocities are perpetrated in the name of religion. People think of themselves as rational (as David Aaronovitch reminded us in his keynote address at the Congress) and then find themselves experiencing irrational things, and believing irrational things, and so they wonder ‘Why?’ Perhaps most of all, people struggle to deal with the suffering imposed by trauma and illness, not least when these illnesses and traumatic experiences are primarily psychological rather than physical in origin or manifestation (as exemplified by Suzanne O’Sullivan’s keynote address). We struggle with the challenges that these things present in national debate (as demonstrated by executive and political keynote addresses), as well as socially, professionally and personally.

The 2015 congress programme included content that touches on some of the major ethical questions of our time, questions that are a common concern for both religion
and psychiatry. Questions were raised concerning allocation of resources in a time of austerity, the part played by psychiatry in responding to terrorism, and the participation of mentally ill and mentally disabled people in their own care, in research, and in the wider affairs of society. There was a session on parity of esteem. Keynote presentations included contributions by a service user researcher, a politician, a sociologist, a teacher, and a journalist, as well as by eminent psychiatrists and doctors (but nothing from a religious leader). There was a play, ‘So you think I am crazy’, written by a service user and carer, and there were two films (both shown in the evening). Why are psychiatrists not given more space at such a congress in which to reflect critically on the spiritual, religious and ethical implications of all of this?

Implicit in the practice of psychiatry, and more explicit in most faith traditions, is an expression of compassion for those who struggle with mental illness. Some speakers at the 2015 Congress were better at articulating this than others, but it was the account of a journalist (David Aaronovitch) speaking about his own illness which most brought alive for me an account of the human suffering which psychiatry seeks to relieve. We need to hear more of this and not allow psychiatry to retreat to a perspective of purely scientific interest within which compassion is all too easily lost.

What does it all mean?

If spirituality and religion share many concerns with psychiatry, I was also struck by some of the things that the programme suggested they do not share. (I’m assuming for a moment that the programme accurately reflects what psychiatry really is currently concerned with, and this is obviously still open to debate.) Whilst starting to reflect on the significance of common human concerns, psychiatry sometimes seems oblivious to other areas of academic scholarship and oblivious to what sense patients and non-psychiatrists might make of things. Somehow, it does not seem to reflect well on the disjunctions between its own view of things and the views of some other professions, disciplines and traditions – especially where these other views and traditions are spiritual or religious.¹

For example, very little attention was given within the 2015 congress programme to meaning beyond a scientific sense of what meaning means. This can leave everything with a very reductionist colouring, which does not reflect the way in which our patients – or most ordinary people – make sense of their lives. Human beings search for meaning, and meaning helps them to cope with adversity, including the adversity of mental illness. Meaning is a key concern of both spirituality and religion.

¹ Of course, there have been notable exceptions to this in the work of individual psychiatrists, as in the cases of Carl Jung, Frank Lake, or of Stanislav Grof, but these personal engagements have not historically affected the attitudes of mainstream psychiatry. They also have tended to be located within very specific spiritual/religious and psychological frameworks, rather than reflecting a wider engagement, independent of particular traditions or theories. My concern here is more with psychiatry as a professional body, or as an academic discipline, in a broader sense.
If voices are really due to errors in source monitoring, and are thus deemed by psychiatrists to be auditory verbal hallucinations, does this mean that they are meaningless? And what does this imply for religious voices, such as those reported by prophets and seers of the world’s major faith traditions, not to mention ordinary religious people seen in the consulting room? Or, again, if delusions, along with religious beliefs and political ideologies are actually (as Richard Bentall suggested) ‘master attributional systems’ which allow us to interpret the world, but which are ‘not required to be logically consistent in the same way as scientific belief systems’, then this leads us to very different conclusions about what purpose and meaning we find in human life. It is frustrating that an academic programme which raises such important questions does not pursue them critically and in depth.

I think that this failure to pursue questions of meaning is associated with a failure to pursue questions concerning the relationship between science and religion. Nor is this only a failing of the conference. The academic literature on science and religion has flourished in relation to physics and evolutionary biology (Polkinghorne, 1998), but has given scant attention to psychiatry. This is ironic, given the vital importance of meaning to the wellbeing of the very patients whom psychiatrists treat.

**Spirituality, Religion, and Psychiatry**

I believe that psychiatry urgently needs to give more and better attention to religion and spirituality. Religion has again become an important issue in public debate, not primarily because of the concerns of doctors about professional practice, but because it is now intimately bound up with international politics and because it shapes the worldview, ethics and culture of most people in society worldwide. Spirituality, although it is in many ways an unsatisfactory term, provides a heading under which many religious and non-religious people find themselves able to talk about the things that matter most to them, including their relationships with themselves, others and a wider reality, and the meaning and purpose that they find in life (Cook, 2004). It is not, in any case, always necessary to use the word ‘spirituality’, as many of these things can be discussed in other terms, but it does provide a convenient way in to an important clinical conversation with many patients and colleagues. If psychiatrists are not basically conversant with the language and concerns of spirituality and religion, they are in danger of becoming out of touch with their patients and with wider society. If they are only superficially conversant with these matters, they all too easily appear unapproachable when it comes to discussing some of the major concerns that their patients face.

Spiritual and religious content also continues to feature prominently in psychopathology. Religious themes appear frequently in delusions and hallucinations, as well as in obsessional ruminations. Religious practice may feature in both addictive disorders and in compulsive rituals. Guilt and anxiety may be associated with religious concerns. The diagnostic significance of all of these phenomena is not readily apparent if the religious context is not properly understood, and in many cases the implications for assessment and treatment are also more widely significant. For example, many
patients with suicidal ideation find themselves exploring spiritual and religious reasons for or against acting upon their thoughts.

Spiritual/religious concerns are important in diverse aspects of treatment planning, as in the importance attributed to spirituality in some addictions treatment programmes, the growing evidence for the benefit of treatments such as mindfulness, compassion focussed therapy and dialectical behaviour therapy (Mace, 2007, Gilbert, 2010), and the development of religiously integrated forms of cognitive behaviour therapy (Koenig et al., 2015). Spiritual/religious concerns play an important part in influencing adherence to prescribed treatments, as in the case of the person who feels that a good Christian (or Muslim, Buddhist, etc.) should be able to manage without medication, or the psychotic patient who believes that their medication interferes with the important spiritual experiences that they are having. All of this is quite apart from the controversial, but important, part played by faith-based organisations (FBOs) in non-statutory service provision (Leavey and King, 2007).

So, as a delegate coming to the 2015 RCPsych Congress from the context of working in a department of theology and religion (as well as in health and social sciences) I was left perplexed by the lack of interdisciplinary engagement with spirituality and religion (and to some extent also the wider domain of arts and humanities). Whatever some psychiatrists may think, many people, both patients and professionals, draw on their understanding of spirituality or religious faith, when coping with adverse circumstances and experiences, not least those presented by mental illness. It is not the case that science alone contributes to our understanding of human wellbeing, or that science alone is ‘logically consistent’. Should we not, therefore, seek to better understand and reflect upon the perspectives that other disciplines and worldviews bring to interpreting experiences of mental ill health and to help finding meaning in life amidst suffering?

References


