

A case for informing patients of the mental health benefits of religion

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Introduction

In the United Kingdom, the received wisdom on the doctor-patient relationship with regard to religion is that it is fundamentally a microcosm of the mostly secular wider public sphere: religion is allowed, but the relevant authorities are reticent to bring it up, and there is a certain anxiety that the potential career cost associated with the subject – regardless of who instigated the discussion – is too great to be worth it. Thus, Alastair Campbell’s famous, ‘We don’t do God’, when Tony Blair was asked about Christianity. And, correspondingly, the concerns among Christians in the NHS (Bowcott, 2009) following the temporary suspension of community nurse Caroline Petrie for offering to pray for a patient in 2008 (Savill, 2009).

Recent political and legal events have yielded mixed signals for Christians. The ascension of a new Conservative government has been met with ambivalence from traditional Christians, who may welcome their contributions to the ‘new visibility of religion’ but who harbour reservations about other parts of their platform. The recent assurance from Theresa May that ‘we would all want to ensure that people at work do feel able to speak about their faith’ (Swinford, 2016) sets some political precedent for an expanded role for Christianity in the public sphere, but as of yet has not been paralleled by any significant legislative or judicial reform. Indeed, it came just days before the deposition of staff nurse Sarah Kuteh on the grounds of various complaints related to her ostensible religious harassment of patients (Finnigan, 2016).

The full details of the latter case are yet to emerge, and indeed it may well transpire that her actions constituted such a breach of professionalism as even most evangelism-minded Christians would disavow. But it nevertheless forms part of the current narrative contributing to the unease of Christians discussing religion in healthcare settings. Even if we suppose that the guidelines in this respect are unambiguous, and that the anxieties are misconceived, the apprehension of Christian clinicians about crossing the boundary may have undesirable consequences. On the one hand, it could push some Christians so far to the opposite extreme that Christian healthcare workers lose out unnecessarily on integrating their spiritual and professional vocations,¹ and on the other hand, it could multiply² and gratuitously deprive patients of a valuable spiritual and mental health resource.³

¹ I take this to be a genuinely important interest, since as a society we want people to flourish, and just as this flourishing involves encouraging and facilitating people to pursue their interests and values and to feel satisfied with their work and life more generally, so the same principle should be extended to those who hold religion to be interesting and valuable. That is not to say that this interest is infeasible.

² ‘Multiply’, since many patients simply appreciate having a sympathetic clinician who shares the same values, beliefs and rituals, and also since – as I argue shortly – religious engagement is positively correlated with improved mental health, the mechanism of which correlation is controversial but probably manifold.

³ There is at the very least robust anecdotal evidence for this, though the quantification of this problem remains an open question: I anticipate that some of the evidence presented herewith goes some way towards answering

My aims in this essay are exploratory and argumentative: I will outline current professional guidance for doctors discussing their personal (including religious) beliefs with patients, before briefly summarising the evidence most relevant to my case. Building on this, I will argue that professional guidance – currently ambiguous – should clarify (in the affirmative) the permissibility of a certain kind of religious discussion: viz., doctors informing patients that religion is associated with improved mental health, regardless of whether the patient has indicated an interest in religion or not. My essay will use a standard academic philosophical and ethical framework: I will lay out the relevant empirical evidence, then offer a *pro tanto* reason in favour of my thesis, and finally argue that there are no counter-considerations overriding this initial reason.

Current guidance

Contra those who think that virtually any substantive discussion of religion between doctor and patient is suspect in the eyes of the General Medical Council, there is some surprisingly liberal counsel offered by the GMC: disclosing personal beliefs is explicitly permitted, and the importance of noting the influence of patients' religious views is noted, but there are clear regulations on such discussions:

'You may talk about your own personal beliefs only if a patient asks you directly about them, or indicates they would welcome such a discussion.' (GMC, 2013a, para. 31)

'You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.' (GMC, 2013a, para. 54)

There is already some ambiguity introduced here: 'indicates they would welcome such a discussion' clearly has a fairly substantial subjective element. Even more unclear, however, is the advice regarding professionalism:

'If you disclose any personal information to a patient, including talking to a patient about personal beliefs, you must be very careful not to breach the professional boundary that exists between you.' (GMC, 2013a, para. 30)

The Royal College of Psychiatrists' guidance is more elaborate regarding the propriety of religious discussion in clinical contexts:

'A tactful and sensitive exploration of patients' religious beliefs and spirituality should routinely be considered and will sometimes be an essential component of clinical assessment.' (RCPsych, 2013, p. 10)

It goes on to reiterate GMC guidance on professionalism:

it. There is also considerable survey evidence suggesting that patients want their religious needs to be addressed (Nicholls, 2002).

‘Psychiatrists should not use their professional position for proselytising or undermining faith and should maintain appropriate professional boundaries in relation to self-disclosure of their own spirituality/ religion.’ (2013, p. 10).

These latter guidelines, similarly, are not as determinative as we might like. In particular, this paper examines one grey area which, it seems, has no clear judgment afforded to it by any current guidelines. This is as follows: is it permissible for doctors to inform patients of the potential mental health benefits of religion, regardless of whether a patient has indicated that they would welcome a discussion of this sort? And is it permissible for doctors to *recommend* religion as part of a treatment plan for certain mental health disorders? And, derivatively, supposing the answer is yes, in what form should this take? I shall primarily be answering the former question, but the reasons I offer in favour of this are at least suggestive of answers we might give to the latter two.

As I explained earlier, even if current guidelines actually permit this, it is far from clear that they do so. But the fact that many doctors do not feel comfortable doing so – and the consequent deprivation of flourishing to doctors and patients to which I pointed – are reasons for correcting this formally by codifying its permissibility and its limits.

It is worth identifying more clearly some of the sources of the ambiguity. There are at least two sources identifiable in the guidance cited. The first is what constitutes a ‘personal belief’. It cannot simply be any belief about which there is widespread disagreement among the general public, since then even descriptive facts like ‘the MMR vaccine does not cause autism’ would escape the doctor’s inventory. Nor can it be any belief about which there is widespread disagreement between doctors, for many treatments for which there is a controversial evidence base ought still to be permitted by the relevant experts so long as they can cite substantial evidence for their case. These definitions are too sensitive in their inclusion of reasonable descriptive counsel from doctors. But other definitions seem too insensitive – failing to exclude some beliefs many would want to count as ‘personal’ and therefore out of bounds. So, for example, defining personal beliefs as normative/prescriptive beliefs, while perhaps capturing a wide range of what we want to exclude – many religious, political and ethical views – will not suffice to rule out descriptive religious beliefs – doctrines about God or beliefs about the historical Jesus, for example. In any case, as I will argue later, it is hardly the case that medicine is already value-neutral: though there is significant scope for individual value systems, doctors and health economists are still required to make some judgments about what constitutes healthy cognition and healthy beliefs about oneself – for example, judging anorexic cognitions to be unhealthy and as warranting discouragement.

In any case, it does not seem as though the fact of the empirical correlation between religious engagement and improved mental health is something that can be excluded from clinical practice on the grounds of it being a ‘personal belief’. It is a fact that can easily be recognised by people of any religious inclination and that has no strict prescriptive entailments. So it is far from clear that the counsel on personal beliefs is the most salient guidance for this case.

What constitutes a professional boundary may be even more opaque. Unfortunately, the explanatory guidance on professional boundaries (GMC, 2013b) pertains primarily to sexual relationships and secondarily to ‘improper emotional relationships’, but it is difficult to see

how the case suggested here amounts to forming an improper emotional relationship. So it is difficult to understand what is meant by professionalism and where the professional boundaries lie. One possibility is that the entirety of the GMC's 'Good Medical Practice' is supposed to constitute professionalism. But this is still not quite adequate, since it makes commands to be professional *within* the document (including the guidance on the case in question) entirely redundant – they amount just to telling doctors to follow the rest of the rules in the guidance. And it is unlikely that the GMC want to claim that 'Good Medical Practice' is comprehensive – that they could not take disciplinary action for lack of professionalism over anything not clearly covered therein. So it seems that 'professionalism' is lacking clear delineation and explication.

The relevant evidence

The literature on religion and mental health is now so extensive that it is difficult to provide a neat summary of it. Major turning-points in assimilating and presenting the overwhelming body of evidence were the publication of Harold G. Koenig's *Handbook of Religion and Mental Health* in 2001, and its follow-up 2nd edition in 2012. The content of the literature is broad: the varied range of psychiatric conditions and the varied aspects of each condition are paralleled by the varied range of religions and aspects of each religion. This leads to an enormous number of permutations of variables, thereby generating a much more complex relationship that does not permit a simple positive or negative evaluation. Beyond this, there are the issues of the mechanisms by which religion is correlated with mental health, the extent to which religion should be involved in healthcare, the direction of the relationship, how mental health is treated within religious communities, and so on. The relevant empirical facts for the present argument, however, are those showing that some reasonably well delineated kinds of religious engagement are associated with improved mental health, and that there is some evidence that there is a causal relationship – though this latter clause is not strictly necessary for the argument.

This main premise is well established and accepted, though there is considerable disparity between the various mental disorders in this respect. In this essay I do not seek to defend this premise, so I take here Simon Dein's summary of the state of the evidence:

On balance those who are more religious have better indices of mental health ... On balance being religious results in more hope and optimism and life satisfaction ... less depression and faster remission of depression ... lower rates of suicide ... reduced prevalence of drug and alcohol abuse ... and reduced delinquency ... Findings in relation to anxiety are mixed ... Work on schizophrenia is still embryonic; recent studies however in Switzerland suggest that religious individuals with psychotic illnesses frequently deploy prayer and Bible reading to help them cope with their voices, and higher levels of religiosity may increase medication compliance. (Dein, 2013)

This does not cover the wide range of psychiatric illness, but the disorders noted here represent the large majority of mental illness in the UK (McManus et al., 2016).⁴ That said, there is a plausible case to be made that mental health is not simply the absence of any disorder characterised in the DSM-V or ICD-10. For one thing, mental health may involve flourishing (the reader may decide whether this may comprise happiness, holiness, or something else) rather than just absence of infirmity. There is not as much evidence pertaining to mental flourishing and religion – perhaps partly on account of its subjectivity – but there are some cross-sectional studies showing improved indices of subjective wellbeing among religious populations in the UK, and particularly among Christians (ONS, 2015; Spencer et al., 2016). Interestingly, in the Office of National Statistics’ Survey, those belonging to religions other than the major religious traditions uniformly had poorer measures of wellbeing (given here as life satisfaction, feelings that life is worthwhile, happiness and lack of anxiety). This may correspond to the fact that ‘People who have a spiritual understanding of life in the absence of a religious framework are vulnerable to mental disorder’, as a recent study concluded (King et al., 2013). This may, in fact, help generate the constraints on my proposal which some critics allege would be too difficult to generate. But the evidence and its interpretation is more rudimentary when it comes to mental flourishing as opposed to mental disorder.

A second similar complication is that, for example, depression is a far more specific diagnosis than low mood. So many people with low mood will not fit the diagnostic criteria for depression, and so may be missed when measuring incidence of depression on a population basis. Depression is characterised not only by low mood but by, for example, self-critical cognition, poor sleep, and poor appetite (or overeating), among other things. It may well be that low mood has a different relationship with religious engagement when compared with the other symptoms of depression. And it may be that low mood falling short of any diagnosis is not represented in many studies, even though it is patently of interest to mental health professionals.

For the purposes of this paper, I cannot explicate the detailed relationship between religion and mental health. I am committed only to the theoretical result that, given that *some* kinds of religious engagement are positively associated with *some* kinds of improved mental health, doctors should be able to inform those with the relevant mental health needs of the benefits of the relevant kinds of religious engagement. I am here only marking the fact that this principle may be extended to a wider conception of mental health if and when the evidence permits it.

A policy proposal

Having briefly described the relevant socio-political, regulatory and scientific contexts, I am now in a position to set forth my proposal:

[Thesis] It should be clearly and formally permissible for clinicians to objectively and dispassionately inform patients suffering from certain mental health problems

⁴ I take it that the distribution of psychiatric illness in the rest of the UK is roughly similar to warrant the generalised claim.

that the relevant kinds of religious engagement are positively associated with improved mental health, even without explicit solicitation from the patient.

There is a *pro tanto* reason⁵ in favour of my thesis as follows: physicians should recommend intrinsically benign⁶ things for which there is good reason to think that they improve health. *A fortiori* (since it is a weaker proposition⁷), they should at least *inform* patients that certain intrinsically benign things probably or plausibly improve health. *A fortiori* still, it should be *permissible* for clinicians to do so, even if not obligatory. That is, something's being conducive to mental health is a *pro tanto* reason to permit clinicians to inform patients about it – at the very least. This much seems uncontroversial. The question is whether there are such countervailing considerations in this case – are there reasons to forbid clinicians from doing so despite the *pro tanto* reason in favour of it? I will argue that there are not.

There is a relative paucity of literature answering the question I have posed in this paper, so the objections given here are generated tangentially: some occur in literature on whether, for example, psychiatrists ought to pray with patients (e.g. Poole & Cook, 2011). I do not have space to discuss all possible objections, so I will identify and briefly rebut the most salient, as they appear to me.

1. Prevention of abuse

At the heart of much objection to the integration of religion and psychiatric practice is that laxity of the professional boundaries which currently resist significant religious integration could invite abuses of the shifted boundaries. Thus, Poole et al. argue, 'The problem with blurring the boundaries by inviting an apparently benign spirituality into the consulting room is that it makes it more difficult to prevent these abuses. Having moved the old boundary it is then very difficult to set a new one' (Poole, 2008, p. 356; see similarly, Carter, 2008). A related objection is that religion can sometimes be harmful to mental health.

In response, I note that vulnerability to abuse is a feature of virtually anything in medicine, and particularly within psychiatric practice. While it may be that drug prescription has tighter regulations and so is less vulnerable to abuse, there are still areas where we permit doctors significant latitude where abuse is possible, because ordinary human interaction would be stifled without it. Thus, expression of sympathy – including tactile – is often appropriate in clinical settings even though it is open to abuse. We already give doctors huge responsibilities and significant laxity such as might admit of abuse. The possibility of abuse is not ordinarily enough to radically restrict doctors' practice: rather, clear guidance regarding what would constitute abuse is ordinarily more appropriate and respectful of religious needs than creating gratuitous and harmful restrictions. The 'harmful' clause applies in this case, since the relevant ban would deprive patients of a potentially helpful element of their treatment.

⁵ A *pro tanto* reason is one which, in the absence of countervailing moral reasons, gives one (overridable) reason to perform an action.

⁶ By which I mean something which is not intrinsically bad.

⁷ A proposition X is weaker than Y if Y entails X but X does not entail Y. It can be formally proved that in such cases, the probability of X is greater than that of Y. Even though the latter claims here are not strictly entailed by the former, it seems clear that they are more plausible than the former.

I briefly alluded to one way in which the relevant regulations might be generated above, when noting that the mental health benefits seem to apply primarily to those within mainstream religions, while the opposite trend is noted in idiosyncratic spirituality. There are other ways in which extensions of my proposal might be regulated, which I do not have time to discuss in detail here.⁸ But most relevantly, my proposal here is implicitly regulated, so does not require any radical revision or vagueness of boundaries. It is simply that where there exists evidence that a certain kind of religious engagement is conducive to mental health, clinicians should be permitted to relay that information to patients. This would set little to no precedent in favour of abuse in more ambiguous situations.

Finally, my proposal is manifestly consonant with existing practice in this area. For the NHS already provides chaplaincy services which might be equally prone to abuse. And GMC guidelines already permit discussion of personal beliefs with patients, subject to various constraints. So there would be no real boundary shift, and nor does it seem as though the mere possibility of abuse is considered sufficient to preclude religious involvement in healthcare. The same is true in this case.

2. Causation and correlation

One objection is that there is no clear causal link suggested, so implying that religious engagement may help the patient may be premature. In response, I note that the premise of the objection is exaggerated. There is some interventional research of relevance (Worthington, 2011), but in any case the implication that randomised controlled trials are the only possible source of causal information is untrue. Observational studies may have considerable evidential force regarding causation when adjustments are made for plausible confounding factors. We did not need a randomised controlled trial to know that smoking is bad for one's lungs.⁹

Further, there is no reason why this cannot be conveyed to the patient. It may be explained to the patient that the evidence is more equivocal than with other interventions, though at least as good as the evidence for many other interventions in medicine. It may be explained that the causal links are unclear but that the association is nevertheless present and may justify religious engagement in the service of mental health. Patients ought not to be condescended to by being kept ignorant about potentially helpful information on the assumption that they could not possibly tell the difference between correlation and causation.

Objections in this vicinity may offer plausible confounding factors rendering the religious element redundant. For example, it may be that being part of a community explains why religious people tend to have better mental health. Then we might simply recommend being part of a community generically rather than mentioning religious communities in particular.

⁸ For example, I also think that prayer should be permitted in clinical practice: one way to protect this from abuse would be to develop set prayers for use in clinical contexts which are ecumenically robust and pertain to less controversial themes within a given tradition: that God heals and comforts within Christianity, for example.

⁹ Thus, the NHS website misleads when it says that 'As a cohort study, this research cannot tell us about any potential causal link between belief and treatment.' (NHS, 2013)

It is probably true that much of the mental health benefit of religion is related to the religious community. That said, it is equally likely that other aspects of religious engagement make their own contributions, so recommending communities generically will not optimise the mental health benefits. Moreover, this is hardly a reason not to mention religion in this context: if religious communities are paradigmatic examples of health-conducive communities, it seems eminently reasonable to note to patients that these are good examples of communities which the patient may consider joining in an effort to advance their own mental health. Finally, even in the unlikely case that the religious element were redundant, this is hardly a reason for *banning* the mention of religion in this context. At the very most, it might suggest that my argument only supports permission, rather than an obligation, for clinicians to give the information in question.

3. Expertise and solicitation

Poole (2011) notes that prayer lies outside doctors' expertise as part of his argument against praying with patients. It may be felt similarly here that religion in general is outside the expertise of doctors. A similar objection might be raised to the 'explicit solicitation' clause in my thesis: patients, especially irreligious ones, visit doctors to improve their health, not to learn about religion. My proposal may be akin to doctors informing patients that the manuscript attestation for the New Testament far exceeds any other text from antiquity. This would be an empirical fact, but would hardly be appropriate (without solicitation, at least) in a psychiatric consultation.

One response here is to note that much of what doctors do is not strictly part of their expertise, and may not be solicited. For example, apart from some interpersonal skills selection before and an occasional communication skills aspect of an examination during medical school, there is precious little substance to the idea that doctors have special expertise at, for example, showing sympathy. And patients may well not be visiting the doctor for sympathy. But yet it seems clear that it is appropriate, and at the very least permissible, for doctors to show sympathy to patients during consultations. Moreover, as Murphy (2015) notes, it is in any case extremely difficult to delineate health vis-à-vis other kinds of human flourishing, so any attempt to restrict doctors' work merely to improving health¹⁰ is unlikely to correspond with current practice and may have political implications – for example, the removal of family planning services from mainstream healthcare – which are unpalatable to many.

But reflecting on the specifics of my proposal again shows independently why these criticisms hold no sway here. Patients may not visit a doctor to learn about religion, but they implicitly solicit expert opinion on mental health, even when the advice may be unexpectedly personal.¹¹ This in mind, given that doctors (and especially psychiatrists) are indeed well placed to know that religion may have a beneficial effect on mental health, there is no reason why my proposal should be seen as an illicit pretence to expertise. And given the implicit

¹⁰ Murphy also notes that some work doctors do is not to do with the treatment or prevention of disease at all, for example, when prescribing contraception.

¹¹ As, for example, when smoking parents are told, unexpectedly, that they ought stop smoking if they want to help improve their young child's respiratory health, or that they should discharge the family pet if they want to avoid a severe allergic reaction.

solicitation for mental health advice, information about religion improving mental health is no less solicited than is the suggestion of an antidepressant with which a patient may previously have been unfamiliar.

4. Neutrality in medicine

Finally, it may be objected that medicine should be value-neutral, or at the very least religion-neutral. Even if we restrict the discussion to *informing* patients about religious engagement as opposed to *recommending* religious engagement, this may be taken as an implicit recommendation of religion, or it may indirectly prioritise some religions over others – since, for example, non-mainstream spirituality is associated with poorer mental health.

It is neither plausible nor current practice to treat medicine as value-neutral. ‘Best interests’ decisions are made frequently with respect to an implied shared set of societal values; certain cognitions (e.g. self-critical ones in schizophrenia, depression or anorexia nervosa) are deemed to be unhealthy and to be rejected and treated; female genital mutilation is to be reported, condemned and prevented; children are taken away from parents when it is judged (rarely) that the living arrangement is not a suitable one, to identify just a few examples. More generally, what constitutes ‘health’ must be decided with respect to certain value judgments: if, for example, there is nothing really wrong with messianic delusions or agitation in patients with dementia, it is difficult to justify treating them without patient consent. This latter point highlights the fact that medicine is not religion-neutral, either: believing that one is the messiah is a religious belief, and it is one which is routinely disregarded and treated (albeit sensitively and politely) without patient consent, using antipsychotics.

I cannot here advance a theory of when and which values and religious beliefs medicine should utilise or contravene. I note simply that medicine is not entirely value- or religion-neutral, and the examples given serve to justify this status quo. So any plausible version of this objection would need to be more specific about how medicine should be neutral. I know of no such objection. Medicine is not value-neutral, it is not evidence-neutral, and it is not religion-neutral. And it is all the better for those.

More saliently, I note for a final time how the detail of my proposal renders this objection obsolete. For in the absence of a *recommendation* of religious engagement, mere information implies no value judgment whatsoever. It merely gives the patients the empirical facts, according to which they can decide according to their *own* value system whether the facts constitute sufficient reason to pursue a management option. This is par for the course in medicine: doctors tell patients that smoking will harm their lungs, that promiscuous sexual activity increase their risk of sexually transmitted diseases, and that continuing a certain pregnancy carries a significant risk of early infant death. It is then the patient’s choice how to weigh up the medical advice within their own value system. The fact that some medical options may be offensive to the patient (for example, the option of terminating a pregnancy) is not ordinarily a reason to withhold the relevant information from the patient. Nor should it be in this case.

Conclusion

Some fellow clinicians have reacted to my thesis with bemusement, as they regard it as trivially true and uninteresting. But given that many doctors still feel uncomfortable informing patients in the way I have described, this is all the more reason for formalising its permissibility. Indeed, as plausible as my thesis is to some, I suspect it will be met with considerable resistance by others, perhaps along the lines of the objections I have considered. I will be grateful to receive such feedback and adjust or abandon my argument accordingly. I regret that I have not had space to deal with all possible objections – I appreciate that there is more to say and hope to say it elsewhere.

If one does think my thesis is trivial, then for the sake of academic interest I invite readers to work out the extensions of my argument to which I alluded earlier – for example, its implications for prayer in medical consultations. My argument provides some support for various other ways of integrating religion into psychiatry and, as I intimated, some support for the stronger thesis that clinicians should be *obliged* to inform patients of the relevant facts laid out here. I leave these extensions, however, as exercises for the reader.

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