

## Psychiatrists, spirituality and religion

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**Psychiatrists, spirituality and religion**  
**Rob Poole, Christopher C. H. Cook, Robert Higgs**

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Title page

**Psychiatrists, spirituality and religion**

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### Summary

Consensus within psychiatry is that patients' religion/spirituality are legitimate topics in assessment and treatment. Religion/spirituality can help people cope with mental illness, but their use as therapeutic tools is controversial. Despite the publication of position statements by national and international psychiatric organisations, there is no clarity over therapeutic boundaries.

## Paper

Over the past twenty years, there has been rapid growth in interest about the interface between spirituality/religion and psychiatry<sup>1</sup>. There has been increased focus on religion and spirituality as important elements of many people's lives, but also a more controversial assertion that they have an important therapeutic role in facilitating recovery from mental illness<sup>2</sup>. Taken together, these two threads have led to a broad movement within psychiatry to encourage more systematic exploration of spirituality and religion with patients and to break down barriers to tackling issues of spirituality and religious faith in clinical practice.

In the UK, this movement developed with very little opposition until 2008<sup>3</sup>. Since that time, we (the authors of this paper) have been prominent in articulating views that are not diametrically opposed, but which are distinct and difficult to reconcile. Debates within psychiatry have been matched by related controversy in the general media about whether Mindfulness, which is based on Buddhist meditation practices, is a legitimate therapy or a cult. As the Royal College of Psychiatrists is presently undertaking an extensive review of its training curricula, it is timely to consider what progress has been made in guiding clinical practice.

*Therapeutic Boundaries*

British psychiatry has long recognised the importance and complexity of therapeutic boundaries in clinical practice<sup>4</sup>. Although one of us is an ordained Anglican and the other two are atheists, we acknowledge that our differences are not simply logical extensions of our beliefs concerning God. We are in complete agreement that there are important issues at stake concerning appropriate therapeutic boundaries. For example, we are agreed that proselytisation of personal beliefs by psychiatrists in therapeutic relationships is always inappropriate, whether those beliefs concern politics, religion or atheism. What we disagree about is the exact location of the relevant boundaries. For example, we strongly disagree over whether there are any circumstances that would make joint prayer permissible in a treatment setting<sup>5</sup>.

There is little evidence available about the views of practising British psychiatrists in general. The literature is dominated by those who have strong opinions. Two of us (RP & CCHC) are members of a research group that has collected data on the subject. We have presented our findings<sup>6</sup>, which suggest that clinicians' judgements over the precise location of proper professional boundaries are more frequently based upon clinicians' perception of consequences for patients than upon fundamental principles of medical or personal ethics (Poole, Robinson, Cook & Song, in preparation for publication). Medical ethics tend to combine utilitarian (based on consequences) and deontological (based on fundamental principles) elements, as each taken in isolation has weaknesses in resolving real life dilemmas. A solely consequential determination of boundaries with regard to religion or spirituality may be vulnerable to an excessive influence of the clinician's personal beliefs and perceptions.

### *Position papers*

The Royal College of Psychiatrists' (RCPsych) Spirituality and Psychiatry Special Interest Group is one of the largest of the College's special interest groups. It embraces a wide range of individuals with an interest in the subject, the majority of whom would regard themselves as either 'spiritual' or 'religious' or both. It includes clinicians who have taken leading roles in promoting the importance of the subject on UK and international platforms. Partly as a result of their influence, both the RCPsych and the World Psychiatric Association (WPA) have issued position statements on the subject<sup>7,8</sup>. CCHC had a hand in preparing both of these documents<sup>9</sup>. South African, German and US national psychiatric associations have also produced guidance on the subject.

The RCPsych's website states "Position statements are approved by the College's Policy and Public Affairs Committee and are concise statements of College policy". Perusal of the list of topics covered by current position statements shows that the organisation tends to make these concise statements mainly on issues that generate controversy. Some position statements serve to prohibit something, for example, psychotherapy aimed at changing sexual orientation. Others are permissive in that they acknowledge that something is acceptable under certain circumstances, albeit with significant caveats. Permissive position papers tend to be cautious, and appear to be compromises between conflicting bodies of opinion.

The Centre for Applied Research and Evaluation International Foundation (CAREIF) is an international mental health charity based in London, led by British psychiatrists. CAREIF has recently produced its own 'Global Position Statement on Religion and Spirituality in Mental Health Care'<sup>10</sup>. In contrast to the RCPsych and WPA position statements, the CAREIF document makes firm assertions that do reflect a particular body of opinion. Some of these assertions are controversial. For example, the document makes a prescriptive recommendation that mental health professionals should "understand how to incorporate religious elements into treatments and care".

We now have three position statements of potential relevance to psychiatric practice in the UK. Although RP and RH are cited in two of these, they are unhappy with the documents. They feel that their own position has been repeatedly misrepresented in the literature as disapproving of all discussion of religion/spirituality in clinical settings, and this is repeated in the CAREIF statement. They are concerned that these statements permit an incremental extension of the clinician's religion into clinical practice in the absence of clarity over boundaries. In contrast, as an author of the RCPsych and WPA position statements, CCHC believes they are helpful but has concerns that the CAREIF document, with a similar title but different emphasis and authority, creates the risk of an unhelpful proliferation of statements with conflicting guidance.

To take an example of problematic permission without boundaries, some atheists consider religion to be intrinsically damaging to human well-being. They might feel that it is acceptable for psychiatrists to work to free patients from the chains of their faith (or dangerous superstitions, as they might see it). None of the three of us feel that this would do anything to promote good mental health or increase the sum of human happiness.

Position statements have an ambiguous status. They usually make reference to evidence but are often a political compromise between diverse interpretations and views. They represent the present balance of informed organisational opinion. Where an organisation can credibly represent a current clinical consensus, position statements do have a purpose. CAREIF is a respectable organisation that has every right to take whatever public stance it feels is appropriate. Indeed, a clear statement of its own stance is helpful, not least because it provokes discussion of the issues. However, it has a far smaller membership than the RCPsych or WPA and can only represent itself. The title 'Global Position Statement' is perhaps unfortunate in suggesting ambitions of global influence, which is exacerbated by a failure to acknowledge the existence of the WPA document.

### *Ways forward*

Attempts to "win" an argument over psychiatry and spirituality/religion are bound to fail. The subject is too complex and multifaceted for that. What is needed is more active engagement and debate beyond a relatively small group of activists. The interface between psychiatry and religion/spirituality has real difficulties, and some of these are more complex than may be immediately obvious. It is in the nature of therapeutic boundaries that some behaviours are definitely out of order, and others are much more ambiguous. The ethical and therapeutic task of maintaining boundaries cannot be achieved through applying a set of rules without consideration of a full range of contextual factors affecting the patient.

Religion and spirituality are unlikely to recede from psychiatry's awareness in the foreseeable future. We need to understand what we agree about and to develop a framework of utility to clinicians to help them decide how to proceed when right and wrong are unclear. In particular, we need to think through the complex power imbalances between professionals and patients. Neglect of this specific issue has led psychiatry into serious error in the past, and will do so in future unless we take active steps to avoid it.

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### **Declaration of competing interests**

Rob Poole and Robert Higgo are atheists

Christopher Cook is an ordained Anglican and a past Chair of the RCPsych Spirituality and Psychiatry Special Interest Group. He writes here in a personal capacity.

### Biographical details

Rob Poole is Professor of Social Psychiatry at Bangor University and Co-Director of its Centre for Mental Health and Society.

Christopher Cook is Professor of Spirituality, Theology & Health at Durham University. He is ordained and he is an Honorary Minor Canon of Durham Cathedral.

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### Authors' contributions

Rob Poole was involved in the conception, drafting, revision and final approval of the article. Christopher Cook was involved in the conception, revision and final approval of the article. Robert Higgs was involved in the conception, revision and final approval of the article.

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For Peer Review



Rob Poole

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