Faith and psychiatry

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Worldviews, spirituality, existentialism, and even religion, atheism and the transcendental, are making a comeback in the language of both the users and the providers of mental health services. The liveliness of correspondence in recent issues of the College's journals and their polarised opinions, the growth of national and international interest groups and the thoughtful papers in this issue of *International Psychiatry* suggest more widespread interest in these topics than was apparent two decades ago (Bhugra, 1996; Cox, 1994). The then anticipated rampant secularism, the predicted death of God and the growth of 'religionless Christianity' have not happened. Instead, multifaith issues, new mainstream churches in Asia and Africa, the wider understanding of Islam and the search for new 'meaning-making rituals' in secular countries have each prompted a renewed interest in transcultural psychiatry, in comparative religion and in psychospirituality (Verhagen *et al*, 2010; Cox & Verhagen, 2011).

There is these days therefore a 'coming out' of the spiritual dimension of mental health service provision in multifaith communities. Although the 'religiosity gap' between service users and providers remains a challenging issue for doctors – particularly for those with no apparent worldview, or for those who unknowingly have incorporated their particular faith tradition into their work-related values, and have difficulty understanding the validity of other traditions. Yet psychiatrists and other health professionals are expected to be more public about their own stance on these matters – which hitherto were regarded as personal and private – and to declare any 'conflict of interest'.

The taboo – don't touch religion – which was a common currency in the 1970s is breaking down, and Freud's apparent antithesis to religion is being replaced by a greater understanding of cultural relativity and of the scientific evidence that religious beliefs can be good, as well as bad, for health (Koenig, 2008). Furthermore, it is now better known that several continental philosophers (Jaspers, Buber, Kirkegaard, Levinas) and Bill Fulford – as chief protagonist for values-based medicine (see Atwell & Fulford, 2007) – have crossed the boundary between religion and psychiatry, and contributed to the philosophy of religion and to a practical theology.

These new developments have led secular countries, which may have lost faith-based healthcare, to rethink their service provision values. They are challenged by the faiths of health professionals from religious countries (Dura Vila *et al*, 2011) and by their patients' desire for a more explicit *médicine de la personne*.

In this issue, Alison Gray, a liaison psychiatrist and Anglican priest, suggests that 'worldview' is a more inclusive concept than religion or spirituality in clinical practice, as it encourages a legitimate exploration of a patient's values and beliefs in a secular setting. She underlines also the necessary task of facilitating insight into the practitioner's own worldview, which, for the religious, may overlap with faith and spiritual practices.

With a different faith perspective, Walid Khalid Abdul-Hamid correctly pinpoints a major gap in ICD-10, which, unlike DSM-IV, had no specific guidance on religion and psychopathology. He urges the ICD-11 Advisory Group to incorporate the best from DSM-IV with regard to both the assessment of religious delusions and the identification of patients referred with religious or spiritual problems but no mental disorder.

Finally, Cristiane Schumann, André Stroppa and Alexander Moreira-Almeida from Brazil cogently point out that faith-based healthcare worldwide makes a huge, but often neglected, contribution to public health. They call for more active evaluation of this provision, which taps religious sources of compassion and altruism.

These three papers should challenge readers of *International Psychiatry*, the academic community and the policy planners at the World Health Organization and national governments. The challenge is to fill in these glaring conceptual and practical gaps in research, education and clinical work – and to reconsider the religious and spiritual dimensions of healthcare. In so doing, the well-being of patients and practitioners is likely to be enhanced, compliance with evidence-based therapies increased, and faith-based healthcare re-energised.

References

Atwell, R. & Fulford, B. (2007) The Christian tradition of spiritual direction as a sketch for a strong theology of diversity. In *Medicine of the Person: Faith, Science and Values in Health Care* (eds J. L. Cox, A. V. Campbell & B. Fulford), pp. 83–95. Jessica Kingsley.

Bhugra, D. (ed.) (1996) *Religion and Psychiatry: Context, Consensus and Controversies*. Routledge.

Cox, J. L. (1994) Psychiatry and religion: a general psychiatrist's perspective. *Psychiatric Bulletin*, **18**, 673–676.

Cox, J. L. & Verhagen, P. J. (2011) Spirituality, religion and psychopathology: towards an integrative psychiatry. *International Journal of Person Centered Medicine*, **1**, 146–148.

Dura Vila, G., Hagger, M., Dein, S., *et al* (2011) Ethnicity, religion and clinical practice: a qualitative study of beliefs and attitudes of psychiatrists in the United Kingdom. *Mental Health, Religion and Culture*, **14**, 53–64.

Koenig, H. (2008) *Medicine, Religion and Health: Where Science and Spirituality Meet*. Templeton Press.

Verhagen, P. J., van Praag, H. M., Lopez-Ibor, J. J. Jr, *et al* (2010) *Religion and Psychiatry: Beyond Boundaries*. Wiley-Blackwell.