Spirituality is about the things that matter most – to all of us. For many patients it is a fundamental aspect of their experience of the human condition that they hope will not be neglected, but about which they may be hesitant to talk to their psychiatrist for fear of censure or misunderstanding. For some psychiatrists, spirituality is fundamental to their vocational calling and may influence their clinical practice (hopefully for good – but potentially also for ill) in diverse visible or invisible ways. For others it is a cause for concern, perhaps even something that they would rather avoid. Spirituality appears in religious and non-religious forms. Even for the minority of people who self-identify as neither spiritual nor religious, their world view, their sense of meaning and purpose in life (or lack of it) and their experience of deeply important relationships with self, others and a wider universe all share many of the central concerns of spirituality. Spirituality is therefore relevant to the work of all psychiatrists.

**Spirituality in Psychiatry: A Brief History**

Historically, much psychiatric care was provided within a religious context. The first specialist institution for the care of the mentally ill appears to have been established in Christian Byzantium in the fourth century. An Islamic facility was established in Fez in North Africa from at least as early as the seventh century (Zilboorg and Henry, 1941, p. 561). The shrine of St Dympna, at Gheel in Belgium, became a place of pilgrimage for people with mental health problems from around the seventh century, with reports of miraculous cures drawing large numbers of pilgrims and, in the thirteenth century, supported a church and a house for the treatment and confinement of the insane (Zilboorg and Henry, 1941, p. 562). In 1247 the hospital of St Mary of Bethlehem was founded in Bishopsgate in London. By the sixteenth century it had developed a special reputation for the care of the insane, and became known as ‘Bedlam’. After two moves within London, it relocated to Kent in 1930 and merged with the Maudsley Hospital, in Southwark, in 1948 (Shorter, 2005, pp. 42–43).

More important than institutions, however, are the attitudes to care which they embody. The Spanish Renaissance philosopher, Juan Luis Vives (1493–1540), a contemporary of Erasmus and Thomas More, gave considerable attention to the humane treatment of the mentally ill, recognising them as suffering from illness and treating...
them with compassion and respect (Zilboorg and Henry, 1941, pp. 180–195). Sadly, a very different approach emerged in the later Middle Ages, with mental illness attributed to demonic possession, albeit that by the end of this period such attributions appear to have been made only in respect of a minority of those suffering from mental disorder (Kemp and Williams, 1987).

The divisions between religion and what we now call psychiatry date back to the European Enlightenment in the seventeenth and eighteenth centuries, and the emergence of empirical, scientific methods for studying the mind and brain (Ansah-Asamoah et al., 2021). Christian care for the mentally ill continued well into this period, increasingly in engagement with humanism and non-religious approaches to care. The so-called ‘moral approach’ to the care of the insane brought about a revolution in care for the mentally ill in the late eighteenth century. Leading figures in this movement were Philippe Pinel (1745–1826) in France, Vincenzo Chiarugi (1759–1820) in Italy, and William Tuke (1732–1822), a Quaker, who established the Retreat at York in 1791 for the humane care of people suffering from mental disorders, in England. In 1856, John Conolly (1794–1866), superintendent of Hanwell Asylum, published The Treatment of the Insane without Mechanical Restraints. That book, and his example of good practice in a major London asylum, were influential in changing practice more widely.

Psychiatry, as a distinct discipline, traces its origins to the beginning of the nineteenth century, when there were remarkable developments in brain localisation and neurohistology, especially in Germany. For Wilhelm Griesinger (1817–1868), all mental illnesses could be understood in relation to brain disease (Shorter, 2005, pp. 119–120). The contribution of this organic, biological approach to psychiatry, neuropathology and especially classification was immense, but at the interface of religion and psychiatry these discoveries encouraged an attitude of reductionism. Mental disorders, as well as healthy mental processes and behaviour, could now be ‘reduced’ to material processes, the human being understandable only as the sum of its biological parts. Reductionism is clinically and philosophically problematic (Karlsson and Kamppinen, 1995), as well as theologically and spiritually objectionable, and this approach to psychiatry was to have a long-lasting and unhelpful influence.

Meanwhile, French psychiatry had reached reductionism by a different route: complex behaviour was thought to occur as a result of unconscious mechanisms, ultimately influenced by the state of the brain. Jean-Martin Charcot’s pupil, Pierre Janet (1859–1947), who was a psychologist and neurologist, had established the beginnings of psychotherapy by the end of the nineteenth century. Religion and faith were not seen as necessary in the quest for explanations of human behaviour.

In Britain, following the publication of Charles Darwin’s On the Origin of the Species in 1859, the concepts of ‘natural selection’ and ‘survival of the fittest’ had profound consequences for the care of the mentally ill. In part this was due to a trend towards discounting everything about the human being, including history and personality, which could not be shown to be clearly organic. In part it was also due to another negative influence on treatment, arising from the theory of degeneration. Popularised by Bénédict-Augustin Morel (1809–1873), notably in his Treatise on Degeneration published in 1857, this theory ascribed psychiatric illness to inherited causes (Shorter, 2005, pp. 181–182). Unlike Darwin, Morel believed that acquired characteristics could be inherited by offspring, and that they would then become more severe in subsequent generations. Whilst the inheritance of acquired characteristics would later be called into
question, these influences presaged modern approaches to psychiatric genetics. They also ushered in several decades of therapeutic nihilism in psychiatry in Britain and elsewhere, inhibiting the search for new, effective methods of treatment.

In the late nineteenth and early twentieth centuries, the influences of psychoanalysis and behaviourism further increased the rift between psychiatry and religion. Sigmund Freud (1856–1939) asserted that monotheistic belief was an illusion, and that religion was a neurosis. For the behaviourists, human behaviour was ‘nothing but’ Pavlovian or Skinnerian conditioning. By the middle of the twentieth century, with science dedicated to material realism, and with the arrival of modernism in philosophy, reductionism had come to dominate medicine. Human beings were understood as little more than intelligent apes. Psychoanalysis was in conflict with traditional religious attitudes, and many churches identified Freud, psychoanalysis and, by association, the whole of psychiatry with atheism, antagonism to religion and a challenge to conventional morality.

By the 1960s, there was little recognition that the patient’s religious beliefs contributed significantly to the psychiatric history, formulation or planning of treatment, and spiritual aspects of the patient’s problem were usually ignored. Biological psychiatry was in the ascendent. In the standard British textbook of the 1960s and 1970s, by Mayer-Gross, Slater and Roth, there were only two references to religion in the index, and religion was assumed to be for ‘the hesitant, the guilt-ridden, the excessively timid, those lacking clear convictions with which to face life’ (Slater and Roth, 1979, p. 180).

In the last decades of the twentieth century, things began to change (Ansah-Asamoah et al., 2021; Cook, 2020). A seminal paper by Allport and Ross (1967), from the USA, showed not only that religiosity took different forms, but also that these different forms had differing implications for human well-being. Importantly, subsequent research has repeatedly shown that intrinsic (inwardly motivated) but not extrinsic (socially motivated) religiosity is good for mental health.

In 1986, David Larson and his colleagues published a systematic review of research on religious variables published between 1978 and 1982 in four leading psychiatric journals, including the American, British and Canadian journals of psychiatry (Larson et al., 1986). Among 2,348 articles that reported quantitative research, only 59 articles could be found in which a religious variable was quantified, and in only three of these was religion the major focus of the study. By the end of the century, research interest in spirituality and religion had increased dramatically. Publications on spirituality in the psychological and healthcare literature increased in exponential fashion during the 1990s (Cook, 2004a).

In 1991, the Patron of the Royal College of Psychiatrists in the UK, HRH The Prince of Wales, urged an approach to mental health care which encompassed body, mind and spirit. Successive presidents of the College (Professor Andrew Sims, and then Professor John Cox) took up the subject in their addresses at College meetings in 1993, and a series of conferences on religion and psychiatry was held at the Institute of Psychiatry in London. In 1997 the Archbishop of Canterbury addressed a joint annual meeting of the Royal College of Psychiatrists and the Association of European Psychiatrists. In 1999 the inaugural meeting of the Spirituality and Psychiatry Special Interest Group was held at the Royal College of Psychiatrists (as discussed later in this chapter; see also the personal reflection on this by Andrew Powell at the beginning of the present volume).

In 1994, the newly published revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association, namely DSM-IV,
included for the first time a category of ‘Religious or Spiritual Problem’. Until this time, references to religion in the DSM had been almost entirely negative, associating it with pathology (Richardson, 1993). The new V code (V62.89) acknowledged that spiritual and religious problems were not necessarily pathological, and encouraged clinicians to be more discerning about the nature of spiritual and religious concerns communicated by their patients.

**What Is Spirituality?**

Spirituality is an abstract concept that is difficult to define. The word ‘spirituality’ has a long history, and its meaning has changed over the centuries. In the English language it derives from the Latin, *spiritualitas*, a word which first appears in the early fifth century, where its use draws on Christian understandings (particularly those of St Paul in the New Testament) of the human spirit as that which is led by the Spirit of God (Principe, 1983). In the twelfth century, use of the term began to change, presaging modern distinctions in which spirituality is opposed to material or bodily aspects of life. In seventeenth-century France the term grew in popularity, but it also acquired a pejorative sense when used to attack ‘la nouvelle spiritualité’ of such writers as Madame Guyon (1648–1717). In the late nineteenth and early twentieth century, the term began to be used by members of religious traditions other than Christianity.

During the course of the twentieth century, the term grew in popular usage, and people started to self-identify as ‘spiritual but not religious’ (SBNR). The SBNR are, in general, less likely to believe in God as a personal being, are more individualistic and disavow exclusivism, religious authoritarianism and religious institutions (Fuller, 2001; Mercadante, 2014; Wixwat and Saucier, 2020). However, the SBNR category may be more about morality and politics than about beliefs or empirical differences (Ammerman, 2013). It can serve to characterise ‘religion’, from a certain unsympathetic perspective, as morally and politically objectionable.

It has been suggested that ‘spirituality’ is merely a privatised, and experience orientated, form of religion (Streib and Hood, 2011) or a mystical religion (Houtman and Tromp, 2021). It shares key features with religion. For example, Linda Mercadante has drawn attention to common concerns such as belief in, and desire to connect with, a transcendent reality, and the use of various rituals and practices to aid this connection (Mercadante, 2014, pp. 5–6). The shared emphasis on transcendence is debatable, and in many ways spirituality untethered to religion is as much concerned with the immanent order as with the transcendent (Cook, 2013c; Houtman and Tromp, 2021). It is also debatable as to whether or not spirituality untethered to religious tradition is actually as individualised and fragmented as it is portrayed to be. For example, Houtman and Tromp (2021) have identified a coherent worldview within ‘post-Christian’ spirituality which emphasises such things as the ‘immanence of the sacred’ and the interconnectedness of things. Within this worldview, experience and emotions play an important part as manifestations of the spiritual/sacred within the self.

There are many possible definitions of the word *spirituality*. For the first edition of this book we provided authors with the following working definition of spirituality as a starting point:

*Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within*
communities, social groups and traditions. It may be experienced as relationship with that which is intimately ‘inner’, immanent and personal, within the self and others, and/or as relationship with that which is wholly ‘other’, transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values. (Cook, 2004a)

This definition was developed from a study of the way in which the concept of spirituality is used in the literature on addiction and spirituality, but it applies equally well to other areas of psychiatry. It emphasises the universality of spirituality as a subjective dimension of the experience of being human, whilst attempting to recognise that this is still, nonetheless, a socially situated phenomenon. Spirituality has come to be perceived as a more inclusive term than religion, acknowledging that a significant number of people in Western countries now see themselves as SBNR. However, a lot of people see themselves as neither spiritual nor religious. In one study in England, 19% of people identified as SBNR, but 46% identified as neither spiritual nor religious, and 35% as predominantly religious (King et al., 2013).

Koenig has argued that spirituality is distinctive by virtue of its connection with the transcendent, or sacred (Koenig et al., 2012, p. 46). As noted earlier, this is debatable. Some spiritual practices are very much about the immanent order, whether or not they also have a transcendent context (Cook, 2013c). Some, perhaps many, people who might consider themselves ‘spiritual’ do not relate to words such as ‘transcendent’ or ‘sacred’. In clinical practice, conversation about spirituality often comes down to those things that matter most – intimate relationships, love, creativity, meaning and purpose in life. One may well ask whether the word is helpful if it can mean so many different things to different people, but it does appear to be helpful in practice. Many patients do want to talk about spirituality (Mental Health Foundation, 2002) and, to this extent, it is at least a word that seems to be good at opening up conversations, not least within the context of psychiatric practice.

Religion

It has been suggested by some that religion is ‘giving way’ to spirituality (Heelas and Woodhead, 2005), or else that the world is becoming more secular. However, the majority of people worldwide are religious. In 2010, 88.2% of the world’s population identified as belonging to a religion. Whilst the comparable figure in 1910 was 99.8%, this has not been a steady decline. In 1970 almost 20% of the world’s population identified as either agnostic (14.7%) or atheist (4.5%). The resurgence of religion since then may be partly attributable to the collapse of European communism (Johnson et al., 2013, pp. 11–12).

Religion, like spirituality, is susceptible to widely varying definitions. Some definitions emphasise the personal and others the social, some emphasise belief and others behaviour, some emphasise tradition and others function, and so on (Bowker, 1999, p. xv). In contrast to religion in general, any religion in particular may be defined in terms of the loyalty of its adherents (Johnson et al., 2013, p. 139). It is not necessarily so much about dogma, beliefs or practices as it is about following, belonging and identity. A religion holds a unique place in the lives of those who see themselves as belonging to it. For our present purpose, it might be helpful to emphasise that religion is also concerned with socially and traditionally shared beliefs and experience, but in placing this emphasis
we must not lose sight of its personal and subjective dimension. Most religious people see their spirituality as bound up with their religion. Relatively few people see themselves as ‘religious but not spiritual’.

In 2010, out of a world population of a little less than 7 billion people, almost a third (nearly 2.3 billion) identified as Christian, with Islam (nearly 1.6 billion) and Hinduism (nearly 1 billion) as the second and third most popular religions, respectively (Johnson et al., 2013). (For consideration of other religions, see Chapter 16.) For clinicians practising in any particular country, the local picture may of course look very different. Much of the research on spirituality and religion in relation to mental health has been conducted in North America and Europe, and so reflects the predominantly Judeo-Christian religious demographics and culture of these continents.

Despite the majority of believers of all creeds living peacefully together, the concept of religion has become associated in the minds of many with fanaticism and violence. For some, as discussed earlier, religion is seen as the antithesis of spirituality. In practice, talk about spirituality may therefore provide an easier way in to conversation about the things that matter. However, in research it has not proved possible to separate distinct factors of spirituality from confounding psychological variables (Koenig, 2008). In research, religiosity is easier to measure.

Religion, religions and religious experiences will be discussed further in Chapter 16. At this point it is important simply to note that most people, worldwide, understand their spirituality in a religious context.

**Mysticism**

Mysticism is yet another term that is difficult to define and has undergone changes of meaning over the centuries. The term has its origins in ancient Greek religions and was taken up by early Christianity. Medieval Christians distinguished between ‘speculative’ theology (which we might understand as an intellectual endeavour) and theology of the affect, or ‘mystical theology’ (which we might understand as Christian spirituality) (Tyler et al., 2018). Today, a mystical element is identifiable within almost all religious traditions, and arguably is fundamental to all religion, but is also identifiable outside of these traditions.

Psychiatry is – or ought to be – concerned with mysticism for a number of reasons. The Group for the Advancement of Psychiatry (GAP), in its 1976 report, identified mysticism as a significant social force, which gives rise to movements that challenge the social order and are attractive to young people of ‘marginal mental health’ (Group for the Advancement of Psychiatry, Committee on Psychiatry and Religion, 1976, p. 812). The GAP report was controversial at the time (Deikman, 1977), and did not show much appreciation of the positive value of mysticism for mental and spiritual well-being. However, some of its conclusions do apply to the aberrant forms of spirituality discussed later in this book (see Chapter 17).

More importantly, mystical experiences share phenomenology with some psychiatric disorders or, to put things the other way around, psychiatric disorders sometimes evidence mystical phenomenology. Mysticism and mystical experience are touched upon in several chapters of this book, and the problem of misdiagnosis is very real (Cook, 2004b). For some, the overlap leads to a conclusion that experiences which might otherwise be considered as evidence of psychosis or dissociation (and historically as
hysteria) should be normalised. For others, it supports the opposite conclusion, that much mystical experience should be diagnosed as psychiatric disorder. To take either of these conclusions to the extreme is not helpful, but there is some truth in both of them, and it is to the credit of the committee that produced the GAP report that it acknowledged its inability to make a clear distinction between mystical and psycho-pathological states (Group for the Advancement of Psychiatry, Committee on Psychiatry and Religion, 1976, p. 815).

The GAP report identified mysticism as involving ‘a relationship with the supernatural which is not mediated by another person’, the goal of which is ‘mystical union’ (Group for the Advancement of Psychiatry, Committee on Psychiatry and Religion, 1976, p. 717). For adherents to a perennialist philosophy, mystical union is understood as a core, common experience identifiable within all religions and (we might now also add) among those who identify as SBNR. However, such views have come under strong criticism from those who would argue that all experience is socially constructed and interpreted, and that there are significant differences between various kinds of mystical experience. W. T. Stace and R. C. Zaehner offer widely cited examples of the contrasting positions.

Stace (1973), in *Mysticism and Philosophy*, suggested that mystical states may be ‘introvertive’ (looking inwards, into the mind) or ‘extrovertive’ (looking outwards), but concluded that both types of mystical states are expressions of a fundamental experience of the unity of all things. The commonality of the experiences is thus emphasised over their diversity.

Zaehner (1973), in his influential book *Mysticism, Sacred and Profane*, identified at least three types – nature mysticism, monistic mysticism and theistic mysticism. In nature mysticism, according to Zaehner, including some drug-induced experiences and those associated with mental disorder, as well as others that occur spontaneously in the absence of any diagnosable disorder, the experience is essentially an atheistic one – an experience of ‘all as one and one as all’ (Zaehner, 1973, p. 28). Monistic mysticism (as in some Eastern religions) takes this a step further, denying the multiplicity of reality, and asserting that there is only one reality, of which the self is a part. This is not really an experience of mystical ‘union’ at all, for there is only one reality. In theistic mysticism (as, for example, in Islam and Christianity), in contrast, the experience of union, the distinction between God and self, is maintained and emphasised. Although the Christian or Muslim may experience a sense of union with God, he/she will always be other than God.

Mysticism may thus be understood as being about experiences of unmediated relationship with God, but it is not necessarily about union, or about God. In his Gifford Lectures in 1901–1902, William James proposed four ‘marks’ of mystical experience – ineffability, noetic quality, transiency and passivity (James, 1902). For James, mystical experience was concerned with relationship with a transcendent, or ‘ultimate’, reality. This relationship could be understood in a very individualistic way, and James rather over-emphasised the personal and subjective nature of the experience. In fact, mysticism is concerned with experiences of the relationship of an individual with both a transcendent reality and a community (often, but not always, a community of faith).

The features of mysticism overlap with those of psychosis and can sometimes present a challenge to diagnosis (Cook, 2004b). The nature of the relationship has been much debated, with some arguing that certain forms of psychosis are associated with spiritual
growth, or else that mysticism may sometimes manifest features of psychosis (Lukoff, 1985). For instance, ecstatic mood, a sense of newly gained knowledge, auditory and visual hallucinations, and concern with mythological themes provide common ground which can sometimes be difficult to interpret phenomenologically.

**Psychiatrists Interested in Spirituality and Religion**

Psychiatrists have, as a profession, often been seen as dismissive of religion. However, the profession has been more sympathetic than sometimes portrayed. In a presidential address to the American Psychiatric Association (APA) in 1956, R. Finley Gayle suggested that the relationship between religion and psychiatry at that time might be understood as one of ‘peaceful co-existence’ (Gayle, 1956). In a presidential address to the Royal College of Psychiatrists (RCPsych) in the UK in 1993, Andrew Sims spoke of the tendency of psychiatrists to ignore and avoid the spiritual (Sims, 1994). What has been needed, at least until recent decades, has been a willingness to countenance a more positive and active engagement with spirituality and religion, something that both Gayle and Sims have strongly supported.

A more positive approach to spirituality and religion within North American psychiatry eventually emerged in the early 1980s (Aist, 2012). However, an ad hoc Committee on Relations between Psychiatry and Religion was authorised at the APA as early as 1956. In 1958 this became a standing committee. The present APA Caucus on Spirituality, Religion and Psychiatry was first convened in May 2012 to facilitate communication and collaboration among members interested in spirituality and religion as a dimension of their work as psychiatrists.²

The Spirituality and Psychiatry Special Interest Group (SPSIG) of the Royal College of Psychiatrists in the UK was inaugurated in 1999, at the initiative of Andrew Powell, in order to facilitate an exchange of ideas among psychiatrists, and to study ‘experiences invested with spiritual meaning’ (Shooter, 1999). Its meetings are designed to enable colleagues to investigate and share, without fear of censure, the relevance of spirituality to clinical practice. The SPSIG aims to contribute a framework of ideas of general interest to the College, stimulating discussion and promoting an integrative approach to mental health care. The diversity of its interests has been reflected in the very wide range of topics discussed at meetings, addressing almost all sub-specialties within psychiatry, as well as such matters as professional boundaries, the nature of evil, prayer, suffering, consciousness and spiritual care within the NHS.

At the time of writing, we are aware of sections or special interest groups devoted to spirituality/religion within the national psychiatric associations of at least seven other countries in addition to the UK and USA, including Austria, Canada, Germany, Hungary, Indonesia, South Africa and Thailand.

The World Psychiatric Association Section on Religion, Spirituality and Psychiatry was established in 2003 to influence clinical practice, encourage research, disseminate findings and develop educational programmes in relation to spirituality/religion and psychiatry (Verhagen, 2019, pp. 23–46).

² I would like to extend my thanks to John Peteet for advice on the dates and developments outlined in this paragraph.
The Spirituality and Religiosity of Patients

It has long been observed that there is a mismatch between the religiosity of patients and their mental health professionals, the former being more likely to believe in God and/or identify as religious than the latter. This is usually referred to as the ‘religiosity gap’. Quantitatively, the size of the gap is difficult to measure, and is very variable in different studies, according to the measures used, nationality and the nature of the comparison groups (if any) (Cook, 2011a). Qualitatively, the gap is manifested by patient reports of perceived disrespect, discomfort, misunderstanding or misinterpretation (Van Nieuw Amerongen-Meeuse et al., 2019). Even if this only happens occasionally, it is a real cause for concern.

Religion or, more correctly, religiosity is a protective factor in and from mental illness. The work that demonstrates this is drawn together in two editions of The Handbook of Religion and Health (Koenig et al., 2001, 2012) and also in a separate volume, Religion and Mental Health (Koenig, 2018). Generally speaking, this now extensive body of published research shows that greater religiosity is associated with less depression, less suicidal ideation, less substance misuse and less delinquency and crime. It is also associated in some studies with less anxiety, but here the evidence is more mixed. Many of the studies are cross-sectional, and the possibility of reverse causation is highly problematic. Individuals may be more anxious because religion makes them so, or else because people pray more and go to church when they are anxious. Where randomised controlled trials of spiritual/religious interventions have been conducted, they generally show that such interventions reduce both anxiety and depression.

During illness, or in times of stress, people use their religious beliefs and spiritual practices as a way of coping. Generally, this appears to be helpful for mental health. However, rates of spiritual/religious coping vary around the world, and evidence for the benefits of such coping is weaker for studies undertaken in relatively more secular parts of the world (e.g., East Asia, and former communist countries). This may again be due to the effects of reverse causation (Koenig, 2018, pp. 59–68). However, there clearly are some circumstances in which religious coping seems to make things worse. So called negative religious coping, in particular religious or spiritual ‘struggles’, fall into this category. Some believers have difficulties with their understanding of, or relationship with, God. Others struggle with their doubts, or with other religious people or forms of spirituality/religion. Cause and effect are very difficult to disentangle, and research to date leaves some doubt as to whether negative religious coping makes mental health worse, or whether poor mental health generates negative religious coping. Quite possibly, causation works in both directions (Koenig, 2018, pp. 177–204). However, in such circumstances it is questionable whether or not religion and mental health can be adequately separated for the purposes of research. For a religious person, mental health and faith are inextricable, each to a large extent being a reflection of the other.

Nevertheless, it has been shown that, in some circumstances, religion can have an unambiguously negative impact on mental health (Koenig, 2018, pp. 295–309) This may be because of:

- a form of spirituality/religion that is harmful to self or others
- a particularly rigid or inflexible (or excessive) way of interpreting and practicing spirituality/religion (e.g., non-adherence to medication due to perceived conflict with beliefs, or a particularly judgemental approach to self or others)
the use of religion to manipulate people
- the use of religion to avoid and neglect social responsibilities (e.g., clergy who spend all their time at work, or lay people who spend all their time at church).

Pathological spirituality of various kinds is discussed further in Chapter 17.

**Spiritual Practices**

Where patients are religious, their spiritual practices and their religious practices will be more or less the same thing. The individualistic and subjective emphasis that has become attached to the concept of spirituality in recent years may confer a sense that some things are more religious and others are more spiritual. Thus, for example, private prayer might more widely be thought of as a spiritual practice, whereas congregational worship might more often be seen as a religious practice. However, such distinctions are dubious, and tell us more about the way in which the use of the word ‘spiritual’ has developed than they do about any inherent or empirical differences between spiritual/religious practices.

Traditional religious practices will be discussed further in Chapter 16. What about the spiritual practices of those who self-identify as SBNR? To some extent, those who are SBNR draw from mainstream religious traditions in a selective and personal way, according to what they find most helpful. This has led to unsympathetic allegations that such spirituality is actually ‘pick-and-mix’ or ‘do-it-yourself’ religion (Houtman and Aupers, 2007). However, a very wide range of other practices, not traditionally thought of as religious, are also understood as spiritual outside the mainstream traditions (and also by some people within them). This diversity of ‘spiritual’ practices stretches the conventional boundaries of what might be considered spiritual or religious. For example, in a 1996 collection of essays titled *Spirituality and the Secular Quest* (Van Ness, 1996), chapters were included on, among other things, holistic health practices, psychotherapies, Twelve-Step programmes, struggles for social justice, naturalistic recreations, ecological activism and sport. Stretching the boundaries in this way might broaden the concept of spirituality so as to be almost meaningless, but that should not distract from the important sense in which such activities are perceived by many as being practical outworkings of their spirituality.

In the influential Kendal Project (Heelas and Woodhead, 2005), more than 50 ‘holistic milieu activities’ associated with spirituality outside of congregational religious contexts were identified, including such things as aromatherapy, circle dancing, foot massage, herbalism, nutritional therapy, play therapy, rebirthing, reflexology, tai chi and yoga groups. To those who practice them, such things may well be understood as a turn towards a spirituality centred on wholeness of being, that seeks to find a balance of body, mind and spirit. They may (or may not) also represent a turning away from material concerns and institutional structures. However, more critically, it has been pointed out that spirituality is a commodity which has been exploited in the corporate world for financial gain (Carrette and King, 2005). Those who are vulnerable by virtue of mental illness may easily find meaning and hope in offerings advertised within this marketplace. However, this does not mean that all such practices are exploitative, or that there is no spiritual value in something that also has a cash value.

One part of the clinical challenge, then, is to explore each patient’s individual sense of what is spiritual and to identify the practices that bring meaning and purpose to life. Sometimes these will be familiar within traditional religious frameworks, and sometimes
they will not. However, it should never be assumed that the patient who says that they do not pray or meditate is unspiritual. Spirituality can take many forms.

**Spirituality in Mental Health Research**

Koenig has rightly drawn attention to the tautological and meaningless way in which much research has contaminated its measures of spirituality with the vocabulary of good mental health (Koenig, 2008). Such traits and qualities as optimism, meaning and purpose, sense of peace or feeling positive about life are as much (or more) measures of mental well-being as they are features of spirituality. Koenig therefore proposes that either spirituality should be defined differently, or else it should be ‘eliminated’ as a research variable. Taking predominantly the latter approach, his research focus in recent years has been on religion or (more precisely) religiosity, rather than spirituality, on the basis that this is measurable without the problems of confounding with mental health variables.

As discussed in more detail in Chapter 16, religion is much more difficult to define than Koenig allows, and the variables that he and others resort to in their quest for the definable, measurable and uncontaminated construct are actually measures of religiousness, or religiosity – the personal expression of religion – rather than religion per se. The word ‘spirituality’ (at least in the English language) does not so easily allow itself to be adapted to distinguish between the conceptual and the personal as the word ‘religion’ does. However, in principle, we can imagine objective measures of ‘spiritualness’ or ‘spiritosity’ which are not confounded with mental health, in the same way that many of the measures of religiosity proposed by Koenig are not thus confounded.

Given that most people in the world are religious, these measures of spiritosity will actually be measures of religiosity. Or, to put things the other way around, religiosity is the measurable manifestation of religious spirituality. This is all well and good in countries where most people are religious (including the Bible Belt in the USA, where Koenig lives and works), just as long as the measures of religiosity work well for members of different religious traditions participating in research. This is not necessarily so easy to achieve. For example, Question 3 in the widely used Duke University Religion Index (DUREL; Koenig and Büssing, 2010) does not work well if you are a member of a non-theistic religion (see Table 1.1). However, where research participants are SBNR, different measures are required. Those who are SBNR do not attend religious meetings, do not tend to have conventional theistic beliefs, and their personal spiritual practices (as discussed earlier) are diverse, but that is not to say that they are not in principle objectively measurable. Houtman and Tromp (2021), for example, have designed a seven-item Post-Christian Spirituality Scale (PCSS) for use in healthcare research that enquires about beliefs in such things as the relationship between spirituality and religion, the nature of the spiritual ‘self’, the encounter of the divine within each person, and the spiritual source of the universe.

A challenge for future research is thus to address the tension between the specific and the general in the measurement of spiritosity/religiosity. On the one hand, research tools are needed to address the specific identities, experiences and practices of those who are SBNR, or otherwise non-theistically spiritual/religious. On the other hand, instruments are needed that enable greater inclusiveness across all spiritual/religious traditions (including those who are SBNR).
By way of example, and as a basis for discussion and reflection, Table 1.1 suggests a possible rewording of the DUREL so as to be inclusive of spirituality as well as religion.

### How Do Spirituality/Religion Help Mental Health?

Koenig (2018, pp. 153–176) suggests that spirituality/religion influences all of the six known determinants of mental health:

1. **Genetic associations.** Genes associated with spirituality/religiosity have also been shown to be associated with altered risk for mental disorder. For example, Anderson et al. (2017) have shown that reported importance of spirituality/religion is associated with particular alleles in the dopamine DRD2, oxytocin, serotonin and vesicular transporter genes in people at low familial risk for depression. A minor allele of the DRD2 gene also appears to increase risk for depression in this group. The associations appear to be suppressed in people at high familial risk for depression. Association does not prove causation, but what we might have here is a biological mechanism by way of which spirituality/religiosity is suppressed and risk for depression is increased. Whether or not this is true, it draws attention to the often neglected scientific evidence that there may be a neurobiological basis for spirituality, as well as for some mental disorders (Perroud, 2009). Spirituality is not a separate domain of life, disconnected from the material (in this case, genetic), but is integrally expressed within the biopsychosocial matrix.

2. **Biological processes,** such as chronic inflammation, immune/endocrine function, modification of brain structure and chromosomal telomere length. For example, Miller et al. (2014) have shown that a thicker cortex in various brain regions is associated with high reported importance of spirituality/religion, and that this may confer resilience against depression in those who are at high familial risk. Although this study in itself does not prove the causal link, we may anticipate that future research will increasingly attend to such processes with a view to establishing (or
refuting) the part that they play. Again, we cannot assume that the underlying mechanisms are not biological, or that if they were this would in any way invalidate the importance of the spiritual. So-called 'hard science' has its part to play in understanding the relationship between spirituality/religion and mental health.

3 **Psychological factors**, such as coping resources (discussed earlier), priorities in life, attachment to God or image of God. An interesting example in this regard is provided by Silton et al. (2014), who showed that belief in a punitive God is positively associated with psychiatric symptoms (social anxiety, paranoia, obsessions and compulsions), whereas belief in a benevolent God is negatively associated with the same symptoms. Based upon this study, at least, belief in God in itself was not significantly related to mental health. However, beliefs about God almost certainly are important. In another study of psychiatric patients, negative images of God were shown to be associated with borderline, avoidant, schizotypal, schizoid, dependent and paranoid personality disorders (Schaap-Jonker et al., 2002).

4 **Social factors**. Religiosity is associated with a series of social variables known to be associated with good mental health, such as social support and marital stability/satisfaction, as well as providing some resilience in relation to discrimination and stigma.

5 **Environment**. The religiosity of parents may, directly or indirectly, influence the developmental environment for children during pregnancy and early life, through such factors as reduced substance use, better social support, and better coping with trauma and deprivation when these occur.

6 **Personal choice**. Religion provides a set of values and expectations that guide prosocial choices (e.g., volunteering), reduce crime and build social capital.

There is thus no shortage of possible mechanisms whereby religion might be understood to exert a beneficial influence in regard to mental health. Some, any or all of them may be important in respect of different disorders or populations.

Most of this research has focused on measures of religiosity. We might speculate that these mechanisms apply also to spirituality as much as to religion, although, as we have noted, research on spirituality – as opposed to religion – encounters particular methodological problems. There is also some reason to believe that being SBNR may not have the same protective effects against mental disorder as does religion (King et al., 2013).

### Spirituality in Psychiatric Treatment

Spirituality is increasingly being included as a component of psychiatric treatment, at least in some countries (notably the USA, but to a lesser extent also the UK and other European countries), in the form of some specific interventions, and also as an independent and dependent variable in treatment research. Furthermore, a variety of faith-based organisations (FBOs) are providing care for people with mental health problems (Koenig, 2005).

Psychotherapy and counselling that are based upon religious frameworks of belief (Rosmarin, 2018), that integrate spiritual approaches, or that are offered within the context of a faith community potentially bring great benefit. FBOs offer a variety of advantages to the delivery of mental health care in such a way as to facilitate the addressing of spiritual/religious concerns, but they also present particular complications and challenges (Leavey and King, 2007). Clergy are often not well informed about mental
illness, just as psychiatrists are not always well informed about spirituality and religion, and the explanatory models that patients bring in respect of their condition may clash with those presented by medicine and science.

A number of different spiritual and religious interventions with a growing evidence base are considered further in Chapter 14. It is also possible to explore spirituality in the secular treatment setting. Organisations such as Alcoholics Anonymous explicitly adopt a spirituality that is open to people of all faith traditions or none (see Chapter 8).

Greater integration of spirituality into psychiatric treatment raises a number of significant questions concerning good professional practice and boundaries.

**Boundaries and Policy**

In 1990 the Committee on Religion and Psychiatry of the APA established guidelines for good practice that were intended to address, in particular, possible conflicts between psychiatrists’ religious commitments and their clinical practice (American Psychiatric Association, 1990). In 2011 the Royal College of Psychiatrists in the UK approved a position statement, *Recommendations for Psychiatrists on Spirituality and Religion* (Cook, 2011b), which makes a series of seven recommendations covering various aspects of clinical and professional practice. They address, respectively:

1. assessment of spirituality/religion
2. respect and sensitivity towards the spiritual/religious beliefs and practices of patients
3. prohibition against proselytising, and an affirmation of the importance of professional boundaries
4. development of organisational policies that promote good practice
5. collaborative working with chaplains and faith leaders
6. respect for and sensitivity towards the spiritual/religious beliefs and practices of colleagues
7. psychiatric training and continuing professional development.

Since then, various other national psychiatric associations have formulated similar policy documents, and the World Psychiatric Association, drawing upon recommendations published by the Royal College of Psychiatrists (Cook, 2013b), has since approved its own position statement (Cook, 2017).

Policy documents and guidelines are helpful to some extent, but they cannot possibly address every clinical situation, and the boundaries of good practice often remain unclear (Poole et al., 2019). The ongoing debate as to what good practice looks like in relation to spirituality/religion has often focused on the importance of good boundaries (Cook, 2013a). It is generally expected that professionals should not operate outside the limits of their training, expertise or competence. They should not impose their personal views about spirituality/religion (whether these are spiritual, religious or atheistic) upon their patients. Perhaps even more controversial is the boundary between the secular and the spiritual/religious. Secular space, it is argued, protects patients against proselytising. However, it can also be experienced as unsafe by patients who want to discuss their spiritual/religious problems with a mental health professional and yet fear that they will encounter a negative and judgemental attitude if they do so. The history of separation between religion and psychiatry, with the legacies of Freud, the behaviourists and some strands of biological psychiatry, have left a suspicion that psychiatry is anti-spiritual and
anti-religious. Added to this, there is the so-called ‘religiosity gap’, with patients more likely to be religious than their mental health professionals. The good clinician therefore needs to be sensitive to all of these considerations in making the consulting room a safe space in which to discuss anything and everything that the patient would like to talk about, including spirituality and religion.

The Royal College of Psychiatrists’ position statement (Cook, 2013b) identifies four possible attitudes that patients (or colleagues) may have towards spirituality/religion:

- identification with a particular social or historical tradition (or traditions)
- adoption of a personally defined, or personal but undefined, spirituality
- disinterest
- antagonism.

Any opening question about spirituality/religion has to be worded and delivered in such a way as to be sensitive to any or all of these possible attitudes. Mishandling of this risks alienating the patient and causing harm. Although some clinicians seem to have a more or less instinctive ability to get such things right, there is also reason to believe that it is easy to get it wrong. There is therefore a need for better training to address the relevant clinical skills and attitudes that enable the clinician to negotiate such encounters successfully and safely.

Training in Spirituality and Psychiatry

Training in spirituality/religion should begin with undergraduate medical education, and is important within all medical professions, including nursing, clinical psychology, psychotherapy and occupational therapy. The focus here will be on postgraduate education, and especially that directed towards the training of psychiatrists.

The World Psychiatric Association and the Royal College of Psychiatrists both have recommendations in their respective position statements concerning the importance of training on spirituality/religion in psychiatry. In the Royal College of Psychiatrists’ position statement, the recommendation is that:

Religion and spirituality and their relationship to the diagnosis, aetiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development. (Cook, 2013b)

A recent report by a Royal College of Psychiatrists’ working group has also advised that person-centred care, in which spirituality is identified as one key aspect, should occupy a central place in the practice and training of psychiatrists (Royal College of Psychiatrists, 2018; Royal College of Psychiatrists Person-Centred Training and Curriculum Scoping Group, 2019). The World Psychiatric Association includes religion and spirituality within ‘general aspects’ of its core training curriculum for psychiatry, but provides no detail as to exactly what this should include (López-Ibor et al., 2002). Around the world, policies and curricula have developed differently. In the USA, in 1994 the Accreditation Council for Graduate Medical Education (ACGME) made spirituality/religion a mandatory component of psychiatric residency programmes (Puchalski et al., 2001).

In the UK, the Competency Based Curriculum for Specialist Core Training in Psychiatry introduced in 2006 by the Royal College of Psychiatrists made passing
reference to spirituality and religion, but largely left these factors implicit within consideration of the cultural context. In the April 2020 revision, spiritual factors were explicitly mentioned only once (in relation to clinical history taking), but again a lot more was said about cultural context, within which religion (if not also spirituality) is arguably an important consideration. The new core curriculum, adopted in 2021, makes no specific reference to spirituality or religion in its high-level learning outcomes, but spirituality/religion have been included in the key capabilities that expand upon what is required in support of each of these outcomes. Spirituality is also included within the draft person-centred holistic model of psychiatry outlined in the ‘Silver Guide’ that provides guidance for psychiatric training in the UK. It remains to be seen whether or not the new curriculum will measure up in practice to the Royal College of Psychiatrists’ position statement recommendation that:

Religion and spirituality and their relationship to the diagnosis, aetiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development. (Cook, 2013b, my emphasis)

Whether or not spirituality and religion are actually addressed in practice during psychiatric training is another matter, and research on this is limited. Since 1994, attention to this element of the curriculum appears to have increased in the USA, but even there only a minority of programs actually teach spirituality/religion to their residents. Elsewhere in the world much less information is available (Bowman, 2009). For example, some interesting work on the curriculum for psychiatric residents has emerged from Brazil (as discussed later in this chapter), but without any information (to date) about how many residents actually receive such training in practice.

What should be taught? It is clear that most psychiatrists will not become experts in the study of religion, and that an in-depth knowledge of the beliefs and practices of all of the world’s major faith traditions is likely to be acquired by very few, if any, medical practitioners. In any case, a patient-centred approach does not require that the doctor should know all about his or her patient’s religion, but rather that he or she should be able to show awareness of the importance of spirituality/religion, and enquire sensitively into what it means to the person seeking his or her help. Many religious people do not adopt or accept all of the orthodox beliefs and practices of their faith tradition, and so assumptions cannot be made. Many people draw on elements of a variety of traditions. For those who identify as SBNR, spirituality is likely to be highly individualistic and subjective.

Curricula for psychiatric training in the USA and UK now commonly include attention to knowledge, skills and attitudes for each of their learning outcomes. Thus, for example, in relation to a learning outcome for assessment, it is clear that the trainee/resident should have the knowledge to recognise the ways in which patients draw on spiritual/religious resources to cope with illness and adversity, the skills to elicit information about the patient’s spiritual/religious beliefs/practices, and an attitude of respect towards these beliefs/practices. Other learning outcomes for which spirituality/religion should be considered especially relevant include those for formulation/diagnosis, investigation, treatment (especially in relation to spiritually integrated psychotherapies) and risk assessment (especially for risk of self-harm). Teaching on the causes of mental disorder requires that attention be given to spirituality/religion as – potentially – both protective and risk factors (usually the former rather than the latter). Communication
and collaboration with patients and professional colleagues (including clergy, chaplains and other religious leaders) are also important components of training within which attention to spirituality/religion should be given particular attention. (For an example of knowledge, skills and attitudes in relation to learning objectives for a psychiatric curriculum in the USA, see Puchalski et al., 2001.)

Kozak et al. (2010) describe a curriculum for psychiatric residents, which was introduced in Seattle in 2003. It is spread across the entire four years of training, and includes didactic teaching as well as rotational clinical experience, grand rounds, case conferences, fieldwork and involvement in a programme of feedback. The stated objectives of the programme were to:

- familiarise residents with the research literature on spirituality/religion in psychiatry
- expose residents to a variety of spiritual/religious traditions
- develop competency in engaging with spirituality/religion in assessment, formulation, differential diagnosis and treatment planning
- consider how patients’ spirituality/religion may affect treatment
- address clinical ethical issues
- consider spirituality/religion in a developmental context
- provide a forum for discussion of residents’ own spirituality/religion and the impact of this on their professional work.

A group of Brazilian psychiatrists (De Oliveira et al., 2020) have recently proposed a curriculum for a 12-hour course, covering historical context, the World Psychiatric Association position statement, assessment of spirituality/religion, spiritual/religious traditions, differential diagnosis and integration of spirituality/religion into treatment. The course employed mixed methods of teaching, including group work, clinical skills (history taking, formulation and diagnosis), discussion of clinical cases, fieldwork and individual supervision, as well as didactic teaching. A residency programme in the USA has also found community partnerships helpful (De Oliveira et al., 2020).

Does training actually make a difference? In a study in Texas of a three-year curriculum for psychiatry residents, McGovern et al. (2017) reported that residents (n = 12) who completed the programme found it to have been helpful, and that 77% of them considered the spiritual/religious needs of patients to be important. However, this study did not compare attitudes before and after training. In another study, from Stanford, California, involving an evaluation of a process-orientated approach to training of psychiatry residents, a six-session course was found to produce a statistically significant improvement in perceptions of competency, and changes in professional practice (Awaad et al., 2015). Unfortunately, this study lacked a comparison group and there was no longer-term follow-up to assess whether or not the changes were enduring.

Furthering Spirituality in Mental Health Care

Spirituality and religion have evoked strong feelings within psychiatry, both among patients and among professionals. Mutual respect for the beliefs of those from different faiths, as well as those not aligned with any faith tradition, are needed, recognising that we can make more headway collectively than individually. It is important that all those
who consider religious and spiritual aspects of psychiatry to be important feel able to work together, whether in local mental health services, in national or international professional bodies or in research. It is also important that professionals and researchers are able to collaborate together with those who do not consider spirituality and religion to be important.

This book aims to make a contribution to tolerance and mutual respect within mental health care. In order to meet the aspirations of our patients, and the appropriate standards of good professional practice, psychiatrists need to be aware of the current debates and controversies, familiar (at least to a basic level) with both the scientific evidence base and the wider field of knowledge concerning spirituality/religion, and competent in the relevant clinical skills. The case for the importance of spirituality/religion in psychiatry is easily overstated or understated, and a measured estimate is required.

In recent years, mental health statutory and voluntary organisations have both become much more aware of the spiritual aspirations of both patients and professional staff (Cook et al., 2012). Faith communities, too, have an important part to play in supporting and caring for people with mental health problems (Corrigan, 2020). By drawing on the insights of faith communities, the experiences of those who are SBNR, and working together across professional and disciplinary boundaries, we can best help our patients to feel safe and listened to. By improving training and continuing professional development, to expand the vision of clergy and mental health professionals alike, we can better ensure mutual respect and understanding. Diversity of spiritual and religious identities of patients and staff brings a greater breadth of perspective to mental health care; recognition and appreciation of this diversity is necessary if patients are to have confidence in the professionals who provide their care.

**Conclusion**

As Swinton puts it (2001, p. 174), psychiatrists and other mental health professionals need to be bilingual, ‘fluent in two languages: the language of psychiatry and psychology . . . and the language of spirituality that focuses on issues of meaning, hope, value, connectedness and transcendence’. We might add here that the many languages of religion are also important. It is probably fair to say that for too long psychiatry has neglected the languages of spirituality and religion to the detriment of the profession and – more importantly – to the detriment of patients. That the language of spirituality is now being heard more widely spoken within the consulting room is very encouraging, but like all languages this one requires practice. Psychiatrists need to be receptive to the words their patients use when talking about religion or spirituality and, at the same time, find ways to translate the language of psychiatry into a vocabulary familiar to their patients – one that includes, and values, spiritual and religious concerns.

Whilst this process of translation is vital, it should not be taken to indicate that spirituality is reducible to the vocabulary of psychiatry, neuroscience and psychology. Spirituality addresses things that are important to deeper understanding of the human condition. The language of spirituality needs to permeate our relationships with our patients and our colleagues, and our whole understanding of the field of psychiatry.
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