

EDITORIAL

The spiritual variable in psychiatric research¹

Foolish as the theory of Durkheim may be in confusing what is religious with what is social, it yet contains an element of truth; that is to say that the social feeling is so much like the religious as to be mistaken for it. (Simone Weil, 1951).

Psychiatrists concern themselves with human mental suffering. Behind the consulting room door they reflect with their patients on questions of meaning and existence, issues that concern philosophy and religion as much as psychiatry. It is striking, therefore, that psychiatrists regard spirituality and religion as, at best, cultural noise to be respected but not addressed directly, or at worst pathological thinking that requires modification (Larson *et al.* 1993).

Despite two millennia of debate we are little nearer a consensus on the meanings of spirituality and religion. The word 'religion' has as many definitions as writers. Spirituality and religion are often used interchangeably. Spilka (1985) doubts that a single definition is even possible. Dittes (1969) argues that religion contains so many unrelated variables that it cannot be considered as a unidimensional concept in research. We would argue that religion is the outward practice of a spiritual system of beliefs, values, codes of conduct and rituals (Speck, 1988). Religious groups may function like any other with codes of behaviour, political alliances and 'in' and 'out' group member ideology (Sherif *et al.* 1966).

Unfortunately, a concentration on the religious variable has led to a failure to appreciate the broader concept of spiritual and the presumption that if someone does not profess a recognized, religious faith, they have no spiritual discernment or need (Speck, 1988). We propose a definition of 'spiritual' as a person's experience of, or a belief in, a power apart from their own existence. It may exist within them but is ultimately apart. It is the sense of relationship or connection with a power or force. It is more specific than a search for meaning or a feeling of unity with others. People may use the word 'spiritual' to describe intense emotional pleasure when moved by natural beauty or by an important relationship. Spiritual belief is more specific than that. Some people may use the word 'God' to describe this power; others may be less specific. Spirituality differs from belief in other powers, such as nuclear power or magnetism, in its 'set apart' quality and the degree to which it is revered and ritualized, the quality which Durkheim (1915) refers to as the sacred.

The topics of magic, witchcraft and religion have figured highly in Western anthropological discourse, although the distinctions between them are far from clear. In non-Western cultures these phenomena are not clearly differentiated and separate words may not exist for them. Generally, in Western monotheistic religions, both magic and witchcraft refer to the manipulation of supernatural entities or agencies by the use of ritual. Religion, however, generally involves a higher God. In our terms, by virtue of the fact that all these supernatural entities are set apart and revered, they may all be called spiritual. The above phenomena are differentiated from superstition, which is an 'irrational fear of the unknown' (*Oxford English Dictionary*) and does not necessarily involve higher powers.

This accords with writers such as Otto (1950) and Eliade (1961) who argue that religions share a core experience of something that may be termed 'holy', 'numinous' or 'sacred'. William James argues 'Religion therefore, as I now ask you arbitrarily to take it, shall mean for us the feelings, acts, and experiences of individual men in their solitude, so far as they apprehend themselves to stand

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in relation to whatever they may consider the divine. Since the relation may be either moral, physical or ritual, it is evident that out of religion in the sense in which we take it, theologies, philosophies and ecclesiastical organisations may secondarily grow' (James, 1902). Spirituality is primary.

This idea of the spiritual does not lend itself to direct measurement by our current methods. Despite its unknown nature, however, we can measure several features of spirituality. The strength of belief in a power apart from our own existence can be regarded as distinct from concepts held about its precise nature. Psychiatrists cannot always describe with certainty what depression is. Patients, however, know when they experience it and rating scales are available to measure how strongly they feel it or how much it affects their lives. In an analogous way the strength of spiritual belief can be measured. Given suitable statistical manoeuvres to control for confounding, its effects in people's lives can be assessed. This pragmatic notion led to an explosion of interest in pencil and paper tests of religion in the late 1950s and later to more sophisticated instruments (Allport & Ross, 1967). The focus of psychological enquiry moved from qualitative descriptions of the phenomena of religious experience (James, 1902) towards a quantitative approach. It is also possible to determine whether the presence of a spiritual belief is predictive of other characteristics or events. Are people who profess a belief in a spiritual force different in other respects from those who do not? Is their mental or physical health better or worse; do they hold different attitudes to their health, work or relationships; or do they behave differently in any given circumstances? Put simply, does it matter? Research of this type has been limited by its use of religious observance, rather than spirituality, as the defining variable.

A number of authors have recently criticized the way that psychiatrists neglect religious or spiritual factors in their practice and research (Kehoe *et al.* 1992; Lukoff *et al.* 1992; Sims, 1994; Crossley, 1995). Only 2.5% of quantitative studies in psychiatry contain a religious variable, in most cases simply the religious denomination of the subject (Larson *et al.* 1986). Data on spiritual belief are almost never collected. Researchers do not even use the few religious variables they collect in their analyses. They frequently overlook important differences in the religious characteristics of their research subjects relative to the populations from which they are recruited (Larson *et al.* 1994). Most religious or spiritual variables are based on the precepts of Western faiths, usually Christianity. Even in domains where research into religion flourishes, the quality can be low (Hunsberger, 1991). In a review of empirical religious research published in four pastoral counselling journals, Gartner *et al.* (1990) reported that few studies stated an hypothesis, used control groups, described a sampling method, included a prospective design or discussed the limitations of their results. Few even contained an analysis of data. Many independent variables in psychiatric research, such as social support, locus of control, quality of life and self-esteem, have now been defined using operational criteria and are better understood. Spiritual belief may be as important as these and we should not ignore it for reasons of personal prejudice or because the variable is conceptually more difficult.

There are several reasons why religious research in psychiatry remains neglected, problematical and unpopular. Psychiatrists are less religious than their contemporaries in the general population and less religiously and spiritually minded than their parents (Toone *et al.* 1979; Neeleman & King, 1994; Neeleman & Persaud, 1995). Psychoanalysts, influenced by the legacy of Freud have traditionally opposed healthy concepts of religion, viewing religion as inducing guilt and dependency. Mental health professionals have associated religion with superstition, intolerance and persecution. Kung (1990) refers to this phenomenon as the 'repression' of religion in psychiatric practice. While general psychiatrists look the other way at the mention of religion, their academic colleagues take flight. Researchers who try to address the issue risk being branded as fanatically religious or as purveyors of soft science in which each variable correlates in some vague way with every other. Journal editors have reacted to poor research methods by demanding higher standards of scientific rigour than pertain in other areas of psychiatric research. Young researchers avoid the area for fear of negative repercussions on their career advancement (Sherrill & Larson, 1994). American psychiatrists have described this phenomenon as the 'anti-tenure factor' of religious research.

Spirituality plays an important part in the lives of many people. In the 1985 National Opinion Poll UK survey (OPCS, 1985), 71 % of people expressed a belief in God. Spiritual experiences occur commonly in the general population. Between 30 and 60 % of people report moments of awareness of a spiritual presence or force (Greeley & McCready, 1974; Hay & Morisy, 1978; Hay, 1987). Many of these spiritual experiences have been well documented in work published by the Alistair Hardy Centre in Oxford. Religion appears to play no less a role in the lives of patients with psychiatric problems (Kroll & Sheehan, 1989; Neeleman & Lewis, 1994). A number of studies suggest that religion is an important help in patients coping with physical illness (Koenig *et al.* 1992), surgical patients (Pressman *et al.* 1990), the bereaved (Palmer & Noble, 1986), patients undergoing palliative care (Dein & Stygal, 1997) and people with work related problems (Pargement *et al.* 1990). Those who are religious may experience less psychological morbidity in the face of adverse life events than those who are not religious. Comprehensive reviews of the area suggest that religion has many positive psychological effects (Brown, 1987; Levin, 1989; Dein, 1996). Few studies, however, consider spiritual belief in addition to, or as distinct from, religious practice. The effects of religious denomination and practice are often confounded by factors such as social support and socio-economic status.

We must clarify whether, and how, we can distinguish a delusion, an over-valued idea and a religious belief. Our simple notions delineating a religious belief from a delusion on the basis of descriptions of the phenomena or, more particularly, their cultural relevance are easily undermined (Jackson & Fulford, 1997). Current views are polarized. There are those who, on the basis of careful phenomenological enquiry, regard pathological and spiritual phenomena as indistinguishable without a consideration of how the phenomena are embedded in the individual's values and beliefs (Jackson & Fulford, 1997). Others see both psychotic and spiritual phenomena as cultural ascriptions (Littlewood, 1997), or complex fields produced by neural activity (Fenwick, 1996), with no 'out there' existence.

A proliferation of scales has continued to be published since Allport & Ross's (1967) measure of religious orientation (King & Hunt, 1975; Paloutzian & Ellison, 1982; Benson & Elkin, 1990; Batson *et al.* 1993). We do not agree, however, with Spilka *et al.* (1985) that we need few, if any, new scales in the psychology of religion. Most of this work is based on the precepts of North American Christianity and the psychometric properties of the instruments have not always been available (Hunsberger, 1991). We need to develop and refine new scales for recording spiritual experiences, and measuring the strength of spiritual belief and the importance of that belief to one's understanding of the world. In a recently developed instrument (King *et al.* 1995), the respondent indicates on a visual analogue scale the strength of their belief and the role of that belief in their lives. Strength of their belief has good test-retest reliability and correlates positively with their religious commitment and practice. Measures such as this must take account of different cultures and religions. Simple measures such as denomination and frequency of religious observance are inadequate measures of belief. They vary between religions and exclude people with no formal religious connection (Levin & Vanderpool, 1987).

There has been a recent resurgence of interest in spiritual and religious variables in research in psychotherapy (Azhar *et al.* 1994), parasuicide (Neeleman & Lewis, 1994) and clinical medicine (King *et al.* 1994). Some research, however, rests on questionable theological and philosophical foundations (Byrd, 1988). A clearer understanding is needed of the prevalence and nature of experiences that people regard as spiritual. More needs to be known about the impact of spiritual belief on human health. We must clarify whether, and how, we can distinguish a delusion, an over-valued idea and a religious belief. Our theories need to be as sophisticated as our methods. Philosophical and empirical study of the spiritual variable must enter into the mainstream of psychiatric research.

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