Conclusions

Worldview is a useful concept to discuss the area where values, meaning and purpose, religion, spirituality and existential issues overlap. All individuals have a worldview, but so too do institutions. A values-based approach helps professionals to work with the worldviews and values of service users and to reach a consensus on the appropriate way forward.

References


The need for a category of ‘religious and spiritual problems’ in ICD-11

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The World Health Organization’s International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders is currently working on the development of ICD-11 (World Health Organization, 2007). A more responsive ICD coding system should incorporate recent work which suggests that the religious and spiritual domain is important for a comprehensive, culturally sensitive diagnosis and management plan (e.g. Sims, 1992, 2004; Koenig et al, 2008). A ‘religious or spiritual problems’ category, similar to that in DSM-IV (American Psychiatric Association, 1994), should be included in ICD-11.

I was alerted to the importance of this domain when undertaking a project in 1988 to assess the mental health problems and psychiatric needs of homeless people in London, using the observer-rated Social Behaviour Schedule (SBS) to detect behavioural problems associated with chronic psychiatric disorder. For one hostel resident, the SBS recorded posturing, mannerisms, and talking and laughing to oneself. There had been no indication of any such problems during a psychiatric interview conducted earlier. What were perceived as ‘behavioural problems’ by the staff were the resident’s daily Muslim prayers carried out in the hostel corridor, as there was no space for prayer in his cubicle.

This experience gave the author an insight into the importance of understanding the nature of religious practices when undertaking psychiatric assessments. Personal spiritual practices, such as prayer or reading from holy books, as well as communal events such as worship and shared prayers, are found in most of the world faiths. ‘Spirituality’ (the quality of being spiritual) is a term used to refer to these practices, corporate rituals and beliefs that give meaning and purpose to life, which may be independent of the institutional structures and prescribed beliefs of a particular world religion.

Psychiatry and religion

Although psychiatry and psychology are linguistically associated with spirit (psyche), their boundary with religion has been fraught with many complications and misunderstandings (Albuquerque et al, 2003). Marks (2006) suggested that the subject of religion in psychiatry and medicine is
often avoided because of its association with the terrifying existential question 'Is this life all there is?' Sims (2004), commenting on the finding that some forms of mainstream religious practice were good for health, asked whether this was epidemiological medicine’s ‘best-kept secret’. Those who were religious were found by Dein (2006) to have a lower incidence of depression and recovered more quickly.

Much of the research in this area has been carried out in Western, high-income countries. Most of the studies reviewed by Koenig et al (2008), for instance, were carried out in Europe and North America. Two recent exceptions may be cited. Abdel-Khalek (2006) surveyed 2210 Kuwaiti undergraduate students using a self-rating scale that covered religiosity, happiness and mental health and found that those who were religious reported greater happiness. Vasegh & Mohammadi (2007) in their cross-sectional study of 285 medical students at Tehran University found that those reporting higher scores on scales assessing religious feeling were less likely to score highly on depression and anxiety, although this association was statistically significant only for anxiety. There is still, though, a pressing need to conduct research in other regions of the world and to review the existing world literature on this subject.

Religion and psychopathology

The American Psychiatric Association’s 1994 classification (DSM-IV) included the category V62.89, ‘Religious or spiritual problems’, in response to the perceived need to assist clinicians working in multifaith communities and to encourage training in this field. This category of problem was not included in the World Health Organization’s 1992 ICD-10, although clinical experience in other regions of the world, as well as the published literature, suggest that religious and spiritual problems are universal, with a consequent need to distinguish, for example, a possession state from a psychotic illness. In many non-Western cultures the patient may ascribe mental disorder to religious beliefs or to spiritual or religious causes. In many traditional cultures there is a strong belief in the power of evil to inflict misfortune and illness, particularly mental illness. In the UK and the USA, about a third of the population report having at some stage of their lives mystical religious experiences of a type that could easily be misidentified by health professionals as mental disorders (Dein, 2004).

The American Psychiatric Association’s Committee on Religion, Spirituality, and Psychiatry has been helpfully proactive in this regard by ensuring greater sensitivity in DSM-IV to religious factors, and this work is continuing with DSM-V. The Association’s book Religious and Spiritual Issues in Psychiatric Diagnosis (Peteet al, 2011) is likely to have international relevance and its content will be pertinent to the development of ICD-11. In summary the DSM-IV category V62.89, ‘Religious or spiritual problems’, is found to be very useful in clinical practice, as is the associated advice about the cultural formulation, which states that this category is used:

when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution. (American Psychiatric Association, 1994)

ICD-10 did not include a similar category to cover these aspects of the religious or spiritual dimension of mental health, which could have provided assistance with complex differential diagnoses. Applying diagnostic criteria without consideration of religious factors could lead to an inappropriate diagnosis and to an inadequate management plan. ICD-11 should therefore encourage greater consideration of religious belief and spiritual practice by incorporating more specific advice in this area of human experience.

References


Psychiatric classification and religion

Any comprehensive diagnostic system should include criteria that ensure that the social, cultural and spiritual contexts are fully considered. This diagnostic approach requires a combination of descriptive and narrative considerations, as well as the need for recovery strategies and for an understanding of the nature of positive health (Cox, 1994).

The present dominant biochemical–behaviourist model emphasises neither these transcultural perspectives nor the humanistic, relationship-based therapies – an apparent neglect that has resulted in the dehumanising of psychiatry and its promotion solely as a technical craft (Albuquerque et al, 2003; Browning, 2003; Meares, 2003).