

# Recommendations for psychiatrists on spirituality and religion

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# Authorship

This position statement was written by Professor Christopher C. H. Cook, MD, PhD, FRCPsych, on behalf of the Spirituality and Psychiatry Special Interest Group. The Executive Committee of the Spirituality and Psychiatry Special Interest Group wishes to record its appreciation of the advice given on the production of this Position Statement by the Policy Committee and Professional Practice & Ethics Sub-Committee of the College.

# Introduction

The aims of this position statement are to affirm the value of considering spirituality and religion as a part of good clinical practice and to provide guidance which will clarify and affirm the boundaries of good practice. It draws upon the current evidence base, published debate, and the aspirations of service users as expressed in published surveys and informal contacts. The Royal College of Psychiatrists believes that such guidance is important for the protection of both patients and psychiatrists. Further, such guidance is necessary in order to ensure that matters of spirituality and religion are not avoided in clinical practice when in fact they may need to be addressed for the benefit of the patient, but at the same time to ensure that a patient's lack of religious or spiritual beliefs is equally respected.

## BACKGROUND

In 1990 the American Psychiatric Association (APA) published *Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitments and Psychiatric Practice*, which emphasised the need for psychiatrists to respect their patients' beliefs and warned against imposition of psychiatrists' beliefs on their patients.<sup>1</sup> These guidelines provide ethical and professional boundaries within which matters of religion and belief may properly be attended to by psychiatrists, for the benefit of their patients, while ensuring that potential conflicts between beliefs of psychiatrist and patient are handled appropriately and that potential abuses are avoided.

The Section on Religion, Spirituality and Psychiatry (SRSP) of the World Psychiatric Association has also pursued a process intended to lead to international agreement on a consensus or position statement on spirituality and religion in psychiatry. This process has not yet resulted in a consensus owing primarily to particular cultural and historical concerns specific to certain member organisations.<sup>2</sup> However, the aspirations in pursuing this process have been similar to those of the APA; the need both to affirm appropriate exploration of the ways in which spirituality and religion should be addressed in psychiatric practice and research, and to ensure that proper boundaries are maintained and abuses prevented.

Recent debate among psychiatrists in the UK has surrounded such matters as the perceived intrusiveness of spiritual assessment within the clinical process, the strength of the evidence base, the danger of boundary violations (e.g. proselytising), concerns about psychiatrists praying with patients, and the lack of training and competence of psychiatrists to address spiritual or religious matters that may arise in the course of clinical work.<sup>3-5</sup>

*Good Psychiatric Practice* requires that a psychiatrist be competent in obtaining a full and relevant history, which includes social and cultural

factors, and in undertaking a comprehensive mental state examination.<sup>6</sup> It further requires that:

'A psychiatrist must provide care that does not discriminate and is sensitive to issues of gender, ethnicity, colour, culture, lifestyle, beliefs, sexual orientation, age and disability' (para. 13).

And again:

'When negotiating the aims and outcomes of treatment plans, a psychiatrist must recognise and respect the diversity of patients' lifestyles, including cultural issues, religious and spiritual beliefs, ambitions and personal goals' (para. 31).

A recent College Occasional Paper, *Improving In-patient Mental Health Services for Black and Minority Ethnic Patients*, has made recommendations for appropriately addressing matters of faith and spirituality within the in-patient setting for members of Black and minority ethnic groups.<sup>7</sup> A recent publication by some of the College's Spirituality and Psychiatry Special Interest Group members and other contributors explores the relevance of spirituality to the clinical practice of psychiatry.<sup>8</sup> However, until now, the Royal College of Psychiatrists has not provided wider guidance or policy on managing matters of spirituality or religion in clinical practice.

## DEFINITIONS

Both spirituality and religion are terms which lack a universally agreed definition, and both are concerned in a broad sense with symbolic systems which provide meaning to everyday life.<sup>9</sup>

Spirituality is usually understood in a more subjective, experiential and individual way, although it does have a social and traditional dimension. For example, it has been defined as:

'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 a 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.'<sup>10</sup>

Religion is usually defined more in terms of systems of beliefs and practices related to the sacred or divine, and definitions often refer to social institutions and communities within which such systems are agreed and held in common. However, others would see religion as much more individual than social, and yet others would focus less on religion as being concerned with belief systems and more on its concerns with morality, praxis or faith.<sup>11</sup>

The scope and variability of definitions for both terms is enormous, with some people identifying spirituality and religion as virtually synonymous, or at least as overlapping concepts, while others see them as contrasting or opposed categories. In many Western countries, both religion and spirituality are now often faced with the context of a secular society, in which most public discourse is conducted without reference to either religion or spirituality. In this context, interest in spirituality has nonetheless burgeoned in recent years. In many other parts of the world, religious tradition continues to provide a shared frame of reference for public life and discourse.

# The evidence base

Whatever disagreements there might be on definition, spirituality and religion are concerned with the core beliefs, values and experiences of human beings. Faith communities, and spiritual or religious practices, have the potential to influence the course of mental illness and attitudes towards people with mental illness, for good or ill. A consideration of their relevance to the origins, understanding and treatment of psychiatric disorders is therefore an important part of clinical and academic psychiatry.

There is now an extensive evidence base in support of the relevance of spirituality and religion in understanding the aetiology of many mental disorders, the benefits of considering spirituality and religion within an overall clinical assessment of a patient's condition, and also the potential benefits of considering spiritual and religious factors within treatment planning. The number of papers published in this field now runs into many hundreds.<sup>8,12-14</sup> Although the bulk of this literature reports positive findings, suggesting that the relationship between spirituality/religion and mental health is a positive one, there are undoubtedly methodological criticisms that can be levelled against much of the earlier research, and also alternative interpretations that may be offered.<sup>15-17</sup> It is clear that religious and spiritual beliefs are powerful forces which may impart harmful as well as beneficial effects.<sup>18</sup>

In addition to the broader evidence for spirituality and religion in relation to psychiatry, there is now particular interest in relation to a number of specific treatments which derive originally from spiritual or religious traditions. Notably, mindfulness-based cognitive therapy is recommended in the National Institute for Health and Clinical Excellence (NICE) guidelines for relapse prevention for people who have experienced three or more previous episodes of depression.<sup>19</sup> Twelve-step facilitation therapy has also been shown to be effective in the treatment of alcohol dependence, especially for individuals with supportive social networks,<sup>20</sup> and there is increasing evidence in support of the value of compassion-focused therapy.<sup>21</sup>

A number of surveys have shown that mental health service users want spirituality to be considered within the context of the overall provision of their care.<sup>22,23</sup> The ability of mental health professionals to address this task appropriately depends upon awareness of religious diversity and ability to explore sensitively a patient's spiritual and/or faith tradition.<sup>24,25</sup> There are anecdotal accounts of the task being handled insensitively in the UK<sup>4</sup> despite the availability of a range of published and established tools to assist in the process of conducting a spiritual assessment.<sup>26,27</sup>

Increasingly, faith-based organisations are becoming involved in the delivery of mental healthcare.<sup>28,29</sup> Mental health professionals therefore need to understand the nature of their involvement and, when necessary, should be equipped to work with them. In some areas of psychiatry, such

as substance misuse, there is also a need to be familiar with 'spiritual but not religious' traditions, such as that of Alcoholics Anonymous and its sister organisations.<sup>30</sup> It is in the nature of contemporary secularity that the search for meaning is now frequently pursued outside established religious or spiritual traditions.<sup>31</sup> The increasingly individualistic and subjective approaches to spirituality that are being pursued in today's world require greater sensitivity and awareness on the part of the psychiatrist than ever before.

Whatever conclusion may be reached on the basis of the evidence, there is now a sufficient body of evidence to suggest that spirituality and religion are at least factors about which psychiatrists should be knowledgeable, insofar as they have an impact on the aetiology, diagnosis and treatment of mental disorders. Further, an ability to handle spiritual and religious issues sensitively and empathically has a significant potential impact upon the relationship between psychiatrist and patient.

# Clinical practice

Spiritual and religious considerations have important ethical implications for the clinical practice of psychiatry. Among the relevant considerations here are the research evidence, the diverse views on spirituality and religion among psychiatrists, and the expressed collective and individual aspirations of mental health service users.

In the course of their work with patients and colleagues, clinicians will encounter a variety of attitudes towards spirituality and religion:

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

If the engagement with the spirituality or religious beliefs and practices (or lack of them) of the other person is mishandled, there is a risk that harm may be caused.

In *Good Medical Practice*,<sup>32</sup> the General Medical Council (GMC) states:

'You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress' (para. 33).

Further guidance is provided in the GMC's *Personal Beliefs and Medical Practice*:<sup>33</sup>

'Trust and good communication are essential components of the doctor-patient relationship. Patients may find it difficult to trust you and talk openly and honestly with you if they feel you are judging them on the basis of their religion, culture, values, political beliefs or other non-medical factors. For some patients, acknowledging their beliefs or religious practices may be an important aspect of a holistic approach to their care. Discussing personal beliefs may, when approached sensitively, help you to work in partnership with patients to address their particular needs. You must respect patients' right to hold religious or other beliefs and should take those beliefs into account where they may be relevant to treatment options. However, if patients do not wish to discuss their personal beliefs with you, you must respect their wishes' (para. 9).

It later continues:

'You should not normally discuss your personal beliefs with patients unless those beliefs are directly relevant to the patient's care. You must not impose your beliefs on patients, or cause distress by the inappropriate or insensitive expression of religious, political or other beliefs or views. Equally, you must not put pressure on patients to discuss or justify their beliefs (or the absence of them)' (para. 19).

# Psychiatric training

Given the evidence base, the clinical relevance and the ethical implications, an understanding of 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.



# Conclusions

The evidence base and service user opinion suggest that spirituality and religion are of significance in clinical practice and research. Good clinical practice requires an awareness of the ethical and professional boundaries associated with spirituality and religion in psychiatry and competence in managing them appropriately, respectfully and sensitively.

# Recommendations

- 1 A tactful and sensitive exploration of patients' religious beliefs and spirituality should routinely be considered and will sometimes be an essential component of clinical assessment.
- 2 Psychiatrists should be expected always to respect and be sensitive to the spiritual/religious beliefs and practices of their patients or to the lack of them, and of the families and carers of their patients. This should normally include allowing and enabling patients to engage in the practice of their chosen spiritual or religious tradition. Where the psychiatrist has reason to believe that this may be harmful, any advice or intervention offered concerning this should be sensitive to: the patient's right to practice their religion; the influence upon their spiritual/religious choices of any illness from which they may be suffering; the views of the family and/or faith community; and advice offered by chaplains or spiritual care advisors.
- 3 Psychiatrists should not use their professional position for proselytising or undermining faith and should maintain appropriate professional boundaries in relation to self-disclosure of their own spirituality/religion.
- 4 Psychiatrists should work to develop appropriate organisational policies which promote equality, understanding, respect and good practice in relation to spirituality and religion.
- 5 Psychiatrists, whatever their personal beliefs, should be willing to work with leaders/members of faith communities, chaplains and pastoral workers in support of the well-being of their patients, and should encourage all colleagues in mental health work to do likewise.
- 6 Psychiatrists should always respect and be sensitive to spiritual and religious beliefs, or lack of them, among their colleagues.
- 7 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.

# References

1. Committee on Religion and Psychiatry (1990) Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitments and Psychiatric Practice. *American Journal of Psychiatry*, **147**, 542.
2. Verhagen PJ, Cook CCH (2010) Epilogue: proposal for a World Psychiatric Association consensus or position statement on spirituality and religion in psychiatry. In *Religion and Psychiatry: Beyond Boundaries* (eds PJ Verhagen, HM Van Praag, JJ López-Ibor, et al): pp. 615–632. Wiley-Blackwell.
3. Poole R, Higgs R (2011) Spirituality and the threat to therapeutic boundaries in psychiatric practice. *Mental Health, Religion & Culture*, **14**, 19–29.
4. Poole R, Higgs R, Strong G, et al (2008) Religion, psychiatry and professional boundaries [Letter]. *Psychiatric Bulletin*, **32**, 356–357.
5. Lepping P (2008) Religion, psychiatry and professional boundaries [Letter]. *Psychiatric Bulletin*, **32**, 357.
6. Royal College of Psychiatrists (2009) *Good Psychiatric Practice. Third Edition* (College Report CR154). Royal College of Psychiatrists.
7. Fitch C, Wilson M, Worrall A (2010) *Improving In-patient Mental Health Services for Black and Minority Ethnic Patients* (Occasional Paper OP71). Royal College of Psychiatrists.
8. Cook C, Powell A, Sims A (eds) (2009) *Spirituality and Psychiatry*. RCPsych Publications.
9. Hanegraaff WJ (2000) New age religion and secularization. *Numen: International Review for the History of Religions*, **47**, 288–312.
10. Cook CCH (2004) Addiction and spirituality. *Addiction*, **99**, 539–551.
11. Bowker J (1999) *The Oxford Dictionary of World Religions*. Oxford University Press.
12. Koenig HG, McCullough ME, Larson DB (2001) *Handbook of Religion and Health*. Oxford University Press.
13. Koenig HG (2009) Research on religion, spirituality, and mental health: a review. *Canadian Journal of Psychiatry*, **54**, 283–291.
14. Verhagen PJ, Van Praag HM, López-Ibor JJ, et al (eds) (2010) *Religion and Psychiatry: Beyond Boundaries*. Wiley-Blackwell.
15. Sloan RP, Bagiella E, Powell T (1999) Religion, spirituality and medicine. *Lancet*, **353**, 664–667.
16. King M, Levey G (2010) Spirituality and religion in psychiatric practice: why all the fuss? *Psychiatrist*, **34**, 190–193.
17. Sloan RP (2006) *Blind Faith: The Unholy Alliance of Religion and Medicine*. St Martin's Press.
18. Crowley N, Jenkinson G (2009) Pathological spirituality. In *Spirituality and Psychiatry* (eds C Cook, A Powell, A Sims): pp. 254–272. RCPsych Publications.
19. National Institute for Health and Clinical Excellence (2009) *Depression: The Treatment and Management of Depression in Adults*. NICE.
20. Project MATCH Research Group (1998) Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism, Clinical and Experimental Research*, **22**, 1300–1311.

21. Gilbert P (2010) *Compassion Focused Therapy: Distinctive Features*. Routledge.
22. McCord G, Gilchrist VJ, Grossman SD, et al (2004) Discussing spirituality with patients: a rational and ethical approach. *Annals of Family Medicine*, **2**, 356–361.
23. Mental Health Foundation (2002) *Taken Seriously: The Somerset Spirituality Project*. Mental Health Foundation.
24. Richards PS, Bergin AE (eds) (2000) *Handbook of Psychotherapy and Religious Diversity*. American Psychological Association.
25. Salem MO, Foskett J (2009) Religion and religious experiences. In *Spirituality and Psychiatry* (eds C Cook, A Powell, A Sims): pp. 233–253. RCPsych Publications.
26. Culliford L, Eagger S (2009) Assessing spiritual needs. In *Spirituality and Psychiatry* (eds C Cook, A Powell, A Sims): pp. 16–38. RCPsych Publications.
27. Aten JD, Leach MM (eds) (2009) *Spirituality and the Therapeutic Process: A Comprehensive Resource from Intake to Termination*. American Psychological Association.
28. Leavey G, King M (2007) The devil is in the detail: partnerships between psychiatry and faith-based organisations. *British Journal of Psychiatry*, **191**, 97–98.
29. Cognac HG (2005) *Faith and Mental Health*. Templeton Foundation Press.
30. Cook CCH (2009) Substance misuse. In *Spirituality and Psychiatry* (eds C Cook, A Powell, A Sims): pp. 139–168. RCPsych Publications.
31. Taylor C (2007) *A Secular Age*. Belknap.
32. General Medical Council (2006) *Good medical practice*. GMC.
33. General Medical Council (2008) *Personal beliefs and medical practice*. GMC ([http://www.gmc-uk.org/guidance/ethical\\_guidance/personal\\_beliefs.asp](http://www.gmc-uk.org/guidance/ethical_guidance/personal_beliefs.asp)).

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