How Spirituality is Relevant to Mental Healthcare and Ethical Concerns

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Introduction

What is spirituality? There are numerous and diverse definitions in the literature which vary according to context and authorship. For some, these all seem far too unscientific or, worse, they represent a dangerous crossing of professional boundaries. In response to such concerns the concept would perhaps better be discarded or avoided in clinical practice and research, at least insofar as this is possible. For others, the term spirituality is simply too confusing to be useful and would better be replaced by a number of different concepts (e.g. those of meaning and purpose in life, forgiveness, and acknowledgement of a transcendent or sacred dimension). However, despite these concerns, and for a variety of reasons, some of which will be considered further here, the concept persists in ordinary conversation, in clinical practice and in academic literature. So, what does it mean?

In a review of 263 papers in the addictions literature up to the turn of the millennium, I identified 13 components to definitions and descriptions of spirituality employed by clinicians, researchers, service users and others (Cook, 2004). Amongst these, relationship, transcendence, and meaning and purpose in life stand out from those that seem to be particularly important, and commonly encountered in practice. For some, it has also seemed important to distinguish (or even define) spirituality as not being concerned with religion, but for others it has seemed impossible to speak about spirituality apart from religion. (Religion is also difficult to define, but might here be considered as beliefs, practices and rituals concerned with the Sacred.) Religion is sometimes characterised as concerned with dogma, institution and hierarchy, perhaps as being more concerned with the social and less with the subjective and experiential. However, there is much overlap and inter-relationship, and it is perhaps best here simply to acknowledge that the two concepts are related in complex and various ways, but that they also need to be distinguished. Not all people are religious. This is evident. However, it can be argued (whilst acknowledging that not all people self-identify as spiritual) that there is a universal dimension of human life that might be labelled spirituality. In a pluralistic and secular society, a universal domain of this kind can provide a space within which to address various matters which concern us all.

A definition of spirituality adopted within the Royal College of Psychiatrists position statement on spirituality and religion (Cook, 2011b) is as follows:

> 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, 2004)

It is not to be imagined that this is an entirely satisfactory definition. It is too long and it lacks clarity and precision. However, it does focus on some of the key issues, it incorporates something of the present debate, and it is sufficiently inclusive of people of all faiths and none to have a degree of utility in practice. Perhaps it can be seen as defining an area of conversation, rather than a concept as such.

How Spirituality is Relevant to Mental Healthcare

But why bother with spirituality at all? In mental healthcare, the answer to this question primarily concerns the needs and wishes of service users. Whilst many psychiatrists may not be spiritual or religious, many patients are (Cook, 2011a). Furthermore, spirituality and religion provide important coping resources during times of ill health and adversity, and the evidence base in support of the value of these resources is growing (Pargament, 2011). Moreover, users of mental health services often find themselves isolated from the support that is usually provided by their faith community – either as a result of hospitalisation, or else as a result of stigma and shame. There is thus a need to assist them in re-engaging with the resources and supports of which they have been deprived.

Spirituality and religious faith also impact upon compliance with treatment. People who identify as spiritual or religious often do not feel that they should need to 'rely' on supports such as those provided by pharmacology or (secular) psychotherapies. Usually, this is a matter of ignorance or misunderstanding, but sometimes (notably in the cases of Scientology or the so-called 'Christian Scientists') it is a matter of the official teaching and beliefs of the group concerned. Faith based organisations are also now providers of mental health care, and psychiatrists need to be aware of the context within which their patients may previously or presently be receiving such care (Koenig, 2005).

Not least, spirituality and religion are now the focus of a huge empirical research literature (Koenig et al., 2001, Koenig et al., 2012). Whilst there is on-going debate about the quality and proper interpretation of this evidence base (Sloan et al., 1999, Sloan, 2006), and whilst more research is still needed, it is not something that can be ignored. Arguments in support of the protective effect of spirituality and religion in relation to much mental morbidity, and in respect of apparently improved outcomes associated with spirituality/religion, are important considerations in research and clinical practice, about which all psychiatrists should be aware. Furthermore, specifically spiritual practices incorporated into treatment (e.g. mindfulness, compassion focussed therapy, twelve-step programmes for addiction, etc.) are now also gaining an evidence base and are increasingly available within the context of the NHS.

In addition to all of these important, but often indirect, considerations, there is also the matter of identifying and addressing the spiritual needs of users of mental health services as a proper part of comprehensive and holistic care. There have been a variety of approaches to describing and classifying spiritual needs, but a helpful scheme is provided by John Swinton (2001):

- Belief and meaning
- Authority and guidance
- Experience and emotion
- Fellowship
- Ritual and practice
- Courage (hope) and growth
- Vocation and consequences

Whilst these are clearly matters that will receive attention from healthcare chaplains, they are also important concerns for all healthcare professionals and all patients – including those who will never see a chaplain. They are thus matters about which all clinical staff should be aware, and to which all such staff should also be ready, when necessary, to respond.

Ethical Concerns

Finally, it must be acknowledged that there are important ethical concerns to be addressed in relation to spirituality in psychiatry. There has been a significant debate about the possible dangers of introducing more attention to spirituality in psychiatric practice (Cook, 2013) and this has been concerned with identifying and respecting proper ethical boundaries and professional good practice, gaining appropriate consent, and the provision of safe clinical 'space' within which patients can be sure that they will not be subject to proselytising or other undue pressure to adopt the values and beliefs of the professional.

The General Medical Council have recently revised their guidance relevant to these matters:

Paragraph 54 of *Good Medical Practice* states:

> You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress (General Medical Council, 2013a)

In *Personal Beliefs and Medical Practice*, the following guidance is given:

> **29.** In assessing a patient's conditions and taking a history, you should take account of spiritual, religious, social and cultural factors, as well as their clinical history and symptoms (see *Good medical practice* paragraph 15a). It may therefore be appropriate to ask a patient about their personal beliefs. However, you must not put pressure on a patient to discuss or justify their beliefs, or the absence of them.

> **30.** During a consultation, you should keep the discussion relevant to the patient's care and treatment. If you disclose any personal information to a patient, including talking to a patient about personal beliefs, you must be very careful not to breach the

professional boundary[1] that exists between you. These boundaries are essential to maintaining a relationship of trust between a doctor and a patient.

31. You may talk about your own personal beliefs only if a patient asks you directly about them, or indicates they would welcome such a discussion. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them. (General Medical Council, 2013b)

In 2011, the Royal College of Psychiatrists published a Position Statement (PS03/2011), *Recommendations for Psychiatrists on Spirituality and Religion* (Cook, 2011b). Within this paper it is pointed out that in any clinical encounter with a patient or colleague, we may find ourselves working with someone who could fall into any one of four groups with regard to spirituality/religion:

- Identification with a particular social or historical tradition (or traditions)
- Adoption of a personally defined, or personal but undefined, spirituality
- Disinterest in spirituality and/or religion
- Antagonism towards spiritual and/or religious matters

Behaviour towards such colleagues and patients will therefore need to be professional and ethical regardless of which of these categories they might identify with.

The reader is encouraged to refer to the full Position Statement for further guidance. However, in summary, its seven main recommendations are as follows:

1. Assessment: tactful and sensitive, routinely considered, sometimes essential
2. Respect and sensitivity to spiritual/religious beliefs and practices (or lack of them) of patients, families & carers
3. Psychiatrists should not use their professional position for proselytizing or undermining faith
4. Psychiatrists should work to develop appropriate organisational policies
5. Psychiatrists, whatever their personal beliefs, should be willing to work with leaders/members of faith communities, chaplains and pastoral workers…
6. Psychiatrists should always respect and be sensitive to spiritual and religious beliefs, or lack of them, among their colleagues.
7. Training & CPD

The core principles, then, are those of awareness, understanding and respect for both colleagues and service users.

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[1] A footnote here states: "You must follow our guidance on maintaining a professional boundary between you and your patient. General Medical Council (2013) *Maintaining a professional boundary between you and your patient* London, GMC."

Summary

It is proposed here that spirituality is highly relevant to clinical practice in psychiatry, that good practice in psychiatry requires that it be given careful attention, and that ethical concerns are not best served by avoiding the subject. Rather, positive attention needs to be given to defining and developing good professional practice in such ways as adequately to address the spiritual needs and concerns that patients express.

References

COOK, C. C. H. 2004. Addiction and spirituality. *Addiction,* 99**,** 539-551.

COOK, C. C. H. 2011a. The Faith of the Psychiatrist. *Mental Health, Religion & Culture,* 14**,** 9-17.

COOK, C. C. H. 2011b. *Recommendations for Psychiatrists on Spirituality & Religion,* London, Royal College of Psychiatrists.

COOK, C. C. H. 2013. Controversies on the place of spirituality and religion in psychiatric practice. *In:* COOK, C. C. H. (ed.) *Spirituality, Theology and Mental Health.* London: SCM.

GENERAL MEDICAL COUNCIL 2013a. *Good medical practice,* London, General Medical Council.

GENERAL MEDICAL COUNCIL 2013b. *Personal beliefs and medical practice,* London, General Medical Council.

KOENIG, H. G. 2005. *Faith and mental health,* Philadelphia, Templeton Foundation Press.

KOENIG, H. G., KING, D. E. & CARSON, V. B. 2012. *Handbook of Religion and Health,* New York, Oxford University Press.

KOENIG, H. G., MCCULLOUGH, M. E. & LARSON, D. B. 2001. *Handbook of religion and health,* New York, Oxford.

PARGAMENT, K. I. 2011. *Spiritually Integrated Psychotherapy,* New York, Guilford.

SLOAN, R. P. 2006. *Blind Faith: The Unholy Alliance of Religion and Medicine,* New York, St Martin's Press.

SLOAN, R. P., BAGIELLA, E. & POWELL, T. 1999. Religion, spirituality and medicine. *Lancet,* 353**,** 664-667.

SWINTON, J. 2001. *Spirituality and mental health care,* London, Jessica Kingsley.