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Position Statement on Religion and Spirituality in Psychiatry: Seven Recommendations

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Summary

Background: in December 2015 the Executive Committee of the World Psychiatric Association approved a Position Statement on religion, spirituality in psychiatry. Since then, the World Psychiatric Association Section of Religion, Spirituality and Psychiatry has committed to publicizing the Position Statement worldwide. **Aim:** to bring this statement, especially the seven recommendations, to the attention of the international psychiatric community, in particular the Russian psychiatric community. **Method:** a narrative review and the seven recommendations in the Position Statement are explained, thus demonstrating its importance. **Conclusion**: religion and spirituality in psychiatry are part of daily psychiatric practice, scientific research, residency training and continuous medical education, and the political and public realm. With the publication of the Position Statement, the Executive Committee of the World Psychiatric Association has made a major accomplishment that benefits psychiatry around the world.

Keywords: World Psychiatric Association, Position Statement, religion; spirituality, dialogue, recommendations

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INTRODUCTION

In December 2015, the Executive Committee (EC) of the World Psychiatric Association (WPA) adopted a Position Statement on religion and spirituality in psychiatry [1]. Since then, the WPA Section on Religion, Spirituality and Psychiatry has made every effort to make this Position Statement (PS) known worldwide. Various translations are now available (Portuguese, Spanish, Hindi, Dutch) and more translations are in process (French, Chinese, Arabic). This article is being published simultaneously with a translation of the PS into Russian.

As Secretary of the WPA Section on Religion, Spirituality and Psychiatry, I took the initiative to adopt a statement on religion and spirituality in psychiatry (this Section was founded in 2003 under the chairmanship of Herman M. van Praag[1]). Since 2006, the Section has sought collaboration with the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists in London. This collaboration led to the publication of a first draft of the PS [2]. However, the EC at the time decided not put this on agenda of the General Assembly during the WPA world congress in Prague — scheduled for September 2008 — because they believed the outcome would be negative. In 2015, after some preparatory work, a revised draft of the document was submitted and approved, after which the PS was published in the February 2016 issue of *World Psychiatry*. In 2018, a theme issue of the journal *Mental Health, Religion & Culture* was devoted to the publication of the Position Statement [3].

The idea of a Position Statement

National and international associations for psychiatry like WAP are accustomed to taking positions in official documents on behalf of the profession with regard to urgent or controversial

[1] Several national organizations now promote the theme of religion and spirituality in psychiatry. For example, the American Psychiatric Association and the Royal College of Psychiatrists (UK) have published statements, and in Brazil, South Africa and India, working groups on religion and spirituality in psychiatry are affiliated with the national organizations. In 2014, the South African association for psychiatrists published a fairly extensive statement on integrating spirituality into psychiatric practice [4]. In 2016, the Deutsche Gesellschaft für Psychiatrie und Psychotherapy, Psychosomatiek und Nervenheilkunde published a PS (DGPPN; [5]). The Dutch Psychiatric Association (NVvP) has recently established its own platform on Religion, Spirituality and Pursuit of Meaning. The Russian Society of Psychiatrists is considering setting up a special religion and spirituality section.

themes. These documents are usually known as position statements or consensus statements.

Within the WPA, drawing attention to and proposing both types of documents is the task of the scientific sections. These sections have the knowledge and experience to identify and prioritize issues that require special attention due to a direct cause or other reasons. After such a proposal, the EC and/or the General Assembly (GA) decide on these issues. Sections can, of course, also work together on position statements or consensus statements. The purpose of such a document is to affirm that a particular theme within psychiatry deserves more than routine attention — not only in daily practice, but also in research and training. For an international organization such as WPA, this theme must be of global importance. The themes addressed are urgent or of great concern. Incidentally, there is a difference between a position statement and a consensus statement. In a position statement, the Executive Committee takes a position on a particular issue. In contrast, a consensus statement has been approved by all members (of national organizations for psychiatry) that are represented at the General Assembly.

The theme of a Position Statement (or a Consensus Statement) must meet five criteria.

1) The theme must be relevant for the further development and practice of psychiatry worldwide.

2) Sufficient scientific research must be available to substantiate the importance of the theme.

3) The corresponding professional organizations require a consensus on the theme.

4) The theme must be important in the public domain.

5) The absence of a Position Statement on the theme could be harmful to psychiatry and patients.

In previous publications I have repeatedly stated that the members of the Section on Religion, Spirituality and Psychiatry are convinced that the theme of psychiatry and religion meets these criteria. Therefore our aim was to arrive at a Consensus Statement, i.e. a statement approved by all WPA members. However, in 2008 and afterwards this turned out to be unfeasible for many reasons that cannot be elaborated here. As a result the emphasis was shifted to a Position Statement [6].

In the present article, I do not reexamine the aforementioned criteria to substantiate the Position Statement and its importance. Instead, now that the Position Statement is in place, I believe it would be much more useful to focus on the seven recommendations and brief comments on these recommendations[2] [7].

RECOMMENDATIONS

1) ***A tactful consideration of patients' religious beliefs and practices as well as their spirituality should routinely be considered and will sometimes be an essential component of psychiatric history taking.***

In the past, authors have often written about the "lost dimension", referring to the disappearance of religion, spirituality and pursuit of meaning from the psychiatric perspective. More recently, a number of developments have had a positive effect on the attitude of psychiatrists in this regard. Transcultural psychiatry has, of course, done a great deal of valuable work when it comes to taking religion and spirituality into account. Due to globalization and the multicultural society, religion no longer presents itself in one of the more or less traditional forms. The results of this situation are clearly visible in the "transcultural interview" in accordance with DSM-5. Religion and spirituality have a clear place in the examination of the patient [8].

This ties in with a second, fairly radical change: the changes as implemented in DSM-IV [9]. DSM-IV introduced the transcultural formulation, which was further developed as indicated in DSM-5. But that was not all. Compared to DSM-III, the glossary had been revised; research showed that religion was used remarkably often in the definition of psychopathological terms. According to the researchers, this was too suggestive and put religion in the wrong light. This was revised in DSM-IV. In addition, a V code (religious or spiritual problem) was introduced in DSM-IV and was retained in DSM-5 (V62.89) [9, 10]. With these changes, without wanting to make it more significant than it actually is, room for a different, more professional attitude was made possible.

A third development that has contributed to a changing attitude of psychiatrists involves the contribution of positive psychology and positive psychiatry. The focus on personal recovery and well-being meant a shift from predominantly weakness-oriented thinking and practicing to strength-oriented thinking and practicing [11]. The

[2] The document consists of two parts: a preamble and a set of seven recommendations. The Mental Health Research Centre in Moscow has posted a Russian translation on the institute's website Документы WPA (psychiatry.ru).

focus in personal recovery is on meaning, purpose, connectedness, and hope. The central theme is living well with illness. In line with this there is a shift in valued outcomes for patients [12]. At the same time, we must conclude that clinical practice, both in outpatient and inpatient services, is lagging behind these developments. One possible reason for this is still what used to be called the religiosity gap [13]. Mental health professionals are less likely to identify with a particular religious tradition. However, from a professional point a view, it is a misapprehension to assume that commitment to a faith tradition is required in order to investigate patients' religious and spiritual needs. A mental health professional needs to be able to listen and act on what the patients themselves express.

The first recommendation means that religion, spirituality and pursuit of meaning can no longer be absent in psychiatric practice. The words "routinely" and "essential" express the importance of religion, spirituality and pursuit of meaning more concretely: these elements can routinely play a role in the story of every patient and are essential to elucidate some aspects of the problem and prevent patients' needs from being ignored. Attention to religion, spirituality and pursuit of meaning is justified and appropriate at the time of psychiatric examination. Many proposals have been made for a "religious anamnesis" or spiritual history, in both an exploratory and in-depth sense. The aforementioned transcultural interview also provides indications for this. Subsequently, the findings can be taken into account in the diagnostic considerations and, if necessary, be included in the treatment plan.

2) ***An understanding of religion and spirituality and their relationship to the diagnosis, etiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development.***

Religion, spirituality and pursuit of meaning play various roles in models of psychopathology: as a vulnerability factor (although there is still limited evidence for this), as a protective and healing factor (there is broader evidence for this), as a symptom-forming factor in psychopathology, and as an expression of psychopathology (there is also fairly ample evidence for this). A differentiated view of religion, spirituality, pursuit of meaning and psychopathology is therefore necessary.

However, models and explanations such as those based on a biomedical model stand in the way of such a knowledgeable view. This also applies to the bio-psycho-social model in so far as it emphasizes the "biological" [12]. Nevertheless, a substantial amount of scholarly literature addresses conceptual issues, such as more differentiated models, e.g. integration of spirituality into the bio-psycho-social model, the stress-vulnerability model [14], enactivism [15], or the 'explanatory pluralism' model [16].

It is clear that training and continuing education must provide practitioners with up-to-date knowledge, skills and an open-minded attitude. Over time, many psychiatric residency training curricula with a focus on religion and spirituality have been presented. Recently, de Oliveira e Oliveira and colleagues proposed a 12-hour course that includes concepts and evidence regarding religion and spirituality, and mental health relationships, taking a spiritual history/case formulation, historical aspects and research, main local religious and spiritual traditions, differential diagnosis between spiritual experiences and mental disorders, and religion and spirituality integration in the treatment approach [17]. The course programme aims to promote a wide range of competencies, skills and attitudinal characteristics (Table 1).

This programme provides an informative overview of what is required of the participants, but each programme should be contextualized according to its specific requirements.

3) ***There is a need for more research on both religion and spirituality in psychiatry, especially on their clinical applications. These studies should cover a wide diversity of cultural and geographical backgrounds.***

There is more than enough scientific evidence to underline the importance of religion and spirituality in psychiatry [18]. For example, research in the general population has shown that pursuit of meaning correlates with a longer lifespan (hazard ratio 2.43; 95% confidence interval 1.57–3.75) [19], better health [20] and a higher quality of life [21]. In a systematic review of 43 clinical studies, 31 studies reported a positive association between religious/spiritual involvement and lower levels of mental disturbance, eight reported both positive and negative associations and two reported a negative association (more mental disorders) [22]. Pursuit of meaning (in the sense of religiosity) was associated with less depression and anxiety, fewer suicide attempts, less addiction and better quality of life, faster recovery from depressive symptoms and better outcomes. In a recent review of prospective studies, Braam and Koenig (2019) also found a positive relationship between religiosity/spirituality and depression outcomes. However, there are also aspects of religion, such as alienation, struggle and awareness of sin, that may have a negative association with psychological health. In addition,

Table 1. Competencies for psychiatry residents (after de Oliveira E., Oliveira F.H.A., Peteet J.R., Moreira-Almeida A. [17])

Knowledge
Residents must show understanding of the following topics: 1. Historical and demographic aspects of religious/spiritual beliefs in different patient populations. 2. Research on the relationship between religious/spiritual beliefs and physical and mental health. 3. Psychodynamic aspects involving religious and spiritual issues in psychopathology (e.g., transference and countertransference)
Skills
Residents must show competence in the following areas: 1. Taking a religious/spiritual history. 2. Incorporating bio-psycho-socio-spiritual elements into the understanding of the patient, reflected in diagnosis and treatment plan. 3. Identifying how their own religious/spiritual beliefs can impact their formulation of the case, the diagnosis, and treatment plans. 4. Recognizing and working on transference and countertransference reactions. 5. Deciding when it is appropriate to refer a patient to or consult with chaplains, spiritual leaders, or healers
Attitude
Residents must show the following attitudinal characteristics: 1. Awareness of patients' religious and spiritual experiences, the impact that these experiences have on their identity and worldview, and biases that could influence patient treatment. 2. Respect for and acceptance of the diversity of cultural and religious experiences

psychiatric symptoms with religious or spiritual content (delusions or hallucinations) may occur. It is therefore crucial that this theme is further elaborated for clinical psychiatric practice.

Although this is starting to change, we also have to ascertain that the actual application in practice of data such as these has been slow. This is surprising because evidence and evidence-based practice play such an important role in psychiatry. Despite the evidence for positive and negative associations between religion and mental health, psychiatrists still seem to be reluctant to take these findings into account. Why? Is that still a blind spot for psychiatrists? Is there still an attitude issue here, or does it involve a lack of education and training? Or is there perhaps a problem with the evidence itself? Is its quality poor, its applicability problematic, or is it not sufficiently relevant? The interpretation and application of the evidence apparently depends on more than just the empirical data; the psychiatrist's attitude also plays an important role in this process. Since psychiatry has taken a critical stance to religion from its beginning, are psychiatrists still adopting a critical attitude to religion and spirituality? This does not mean that professionals should take a religious position themselves, but they should be able to integrate religion and spirituality into their professionalism based on a reflective (and self-reflective) attitude [6, 24].

4) ***The approach to religion and spirituality should be person-centered. Psychiatrists should not use their professional position for proselytizing for spiritual of secular worldviews. Psychiatrists should be expected always to respect and be sensitive to the spiritual/religious beliefs and practices of their patients, and of the families and carers of their patients.***

While there is growing awareness that spiritual experiences and religious practices can be important to patients, the issue remains controversial and the attitudes of psychiatrists are ambiguous. A persistent objection is the risk of psychiatrists crossing ethical boundaries, i.e. that psychiatrists would impose their own beliefs on patients or compel patients to reveal their religious beliefs. Every document on professional ethics states that physicians/psychiatrists should never impose their own beliefs on patients, and should only raise those beliefs for discussion if this is somehow relevant to the patients' treatment and care. In other words, the ethical guidelines are very clear [25].

The verb "to impose" is a frequently used keyword in the discussions on the attitude of the psychiatrist to religion. Almost every guideline-like document with regard to religion and spirituality in psychiatry states that psychiatrists should not *impose* their religious or secular views on their patients. Beyond

ethical principles, it seems reasonable to assume that this reluctance stems from at least two influential sources. Firstly, Max Weber (1864–1920) was very outspoken in his resistance to impose personal values on science [26]. Under increasing pressure of a process of rationalization, Weber separated facts and values, science and religion; his influence was enormous for decades. Secondly, such imposing is a serious violation of psychoanalytic principles. Blass illustrates this point by citing the fact that Freud himself admitted that he was *imposing* his theories on his patients at a certain stage of his work, which certainly had clinical impact. According to Blass, conviction or belief can "arise either from a seductive wish (the imposition of ourselves upon reality) or from our basic openness to truth (the imposition of reality upon us)" [27].

This sheds yet another light on the fact that empirical data on its own is not sufficiently convincing. Over time, several keywords have been used to characterize psychiatrists' mindsets toward religion: they confess, they don't believe, they fight, they suspend judgment, or remain undecided. However, having a responsible belief or judgment is an ongoing reflective obligation, and reworking our doxastic mindset (belief, disbelief, suspension of judgment) is a professional requirement. That mindset emanates in part from a desire to know (or not to know); in psychoanalytic jargon this is called the epistemophilic instinct, i.e. an instinct for research [27]. Knowledge is not something in itself. We relate to knowledge as we relate to objects. "(W)e love things, hate things and we want to know things (...)". "... (as) we also need to be loved, fear being hated and want to be understood" [28]. This desire for truth or knowledge obviously has dangers and pitfalls. One of these is "the danger of thinking we know truth, of being convinced of truth, while in fact we do not — while in fact we are *imposing* our preconceived convictions on reality" (italics added) [27]. Doubt would be the better alternative, although it could be based on "fear of *imposing*" (italics added) [27]. According to Blass's interpretation of Freud, when we are able to discern our dangerous wishes from a stance of openness to reality, then we can trust what we know [27]. Only then will there be professional space for respect and sensitivity to the spiritual/religious beliefs and practices of patients, and of their families and carers.

5) ***Psychiatrists, whatever their professional beliefs should be willing to work with the leaders/members of faith communities, chaplains and pastoral workers and others in the community, in support of the well-being of their patients, and should encourage their multi-disciplinary colleagues to do likewise.***

In 2014 APA president Paul Summergrad launched his initiative for partnering with interested clergy "to improve understanding of mental illness and to reduce stigma in communities of faith" [29]. Initiated by an opinion leader such as the APA president, this step resulted in an enormous impetus, especially since psychiatry has long neglected collaboration with clergy and spiritual leaders. A mental health guide for faith leaders as a product of this partnership followed in 2018 [30]. Partnership and collaboration is also one of three dimensions of the strategic framework of the WPA Action plan 2017–2020 [31].

Initiatives are also being launched from the other side. The World Council of Churches, noting that churches play an important role in the health landscape and reaffirming that health and healing are central features of Christian ministry, developed its Health-Promoting Churches programme [32]. The programme is based on four principles:

1) The church is a place of health education.
2) The church is a place of practical action.
3) The church is a place for advocacy and care for creation.
4) The church is a place of empowerment for public witness.

I will not go into the theological explanation and premises of these principles, but the message is clear and straightforward. We cannot achieve any health-related targets unless we work together with and empower local communities. In concurrence with its American counterpart, the programme states that churches can help to promote mental help by addressing stigma and discrimination, by upholding human rights and dignity, by ensuring skilled health workers, and by providing care and support [32, 33].

Another welcome initiative took place in Moscow. In 2018 and 2019, the Moscow Patriarchate of the Russian Orthodox Church held an international conference recognizing the common responsibility of clergy and medical professionals in church care for mentally ill people (Department of External Church Relations of the Moscow Patriarchate, 2019[3]).

The positive challenge of the recommendation to work on collaboration can also be illustrated based on preliminary research findings with several objectives. Research has shown that churches are looking to adapt religious practices to certain mental health conditions, e.g., dementia [34]. Other research has investigated the collaboration between professionals, for example between chaplains and nurses [35], or the desired collaboration between clinical psychologists and spiritual-religious healers [36]. The effects of certain interventions, such as prayer in management of pain, are reviewed [37].

[3] The conference reports of 2018 were published by the Department for External Church Relations of the Moscow Patriarchate in 2019; the conference reports of 2019 are in preparation for publication.

These findings illustrate the interest in the field and reveal many possibilities and approaches that, while there are limitations, open up an area that can advance the idea and intention of collaboration.

6) ***Psychiatrists should demonstrate awareness, respect and sensitivity to the important part that spirituality and religion play for many staff and volunteers in forming a vocation to work in the field of mental health care.***

The sixth recommendation alludes to an aspect of doing one's work — paid or voluntary — that probably is no longer as familiar as it used to be. However, we know that many staff and volunteers can perceive what they refer to as a calling. That perception is worthwhile to them and must therefore be respected. So it might be helpful to reflect briefly on the construct of "a calling". This construct can be divided into 1) a person's attitude towards the demands of life, 2) a person's intention to work with his talents, 3) the way in which a person gives substance to his or her discipleship or being a follower or leader of a religious or spiritual tradition [38]. This is known as "primary calling". Its expression — "secondary calling" — becomes visible in the person's commitments. The most important part of a calling is its identity value. In that sense, a vocation is part of one's identity, and one lives according to and grows in one's calling, and vice versa. There is no need to limit a view on calling to a Christian narrative. In addition to views on vocation with a strong religious orientation, there are also spiritually and humanistic oriented views. For instance, calling is what a person perceives as his or her purpose in life [39]. Recent studies have shown that the concept of vocation has continued to develop in parallel to changes in the meaning of concepts in the religious and spiritual domain: from "being called to follow Christ" to a more self-focused concept, as in the previous description. A calling is anything but an old-fashioned concept. Connected to positive health, vocation is aimed at self-development and flourishing [39].

A strategy to do more justice to cooperation with and respect for vocation is to work in a multidisciplinary context on a joint approach and set of practice guidelines. How do we work on a division of tasks between practitioners, nurses and case managers, staff with experiential expertise, and spiritual carers? What tools with regard to diagnostics, methods and interventions (and the corresponding ethical aspects) are available in the area of pursuit of meaning and spirituality, and how can these be implemented? The perspective of patients, clients and close relatives is the starting point. The "religiosity gap" has always played a role here: patients and clients — as well as nurses — usually attach more value to religiosity, spirituality and pursuit of meaning than psychologists and psychiatrists. The care needs of patients and clients in the area of pursuit of meaning and spirituality therefore require attention. This also creates the opportunity to prioritize and improve the position of spiritual carers in mental health care and enhance their collaboration with other disciplines. In this way it should become possible to fulfil religious and spiritual needs, vocation and ethical principles with very professional conduct [40].

7) ***Psychiatrists should be knowledgeable concerning the potential for both benefit and harm of religious, spiritual and secular worldviews and practices and be willing to share this information in critical and impartial way with the wider community in support of promotion of health and well-being.***

I would like to mention a few aspects related to this recommendation that touch on the competence health advocacy. There is no doubt that health (including mental health) is a public and political issue. Religious or spiritual well-being was not included in the outmoded (1948) definition of health proposed by the World Health Organization (WHO). Since then new definitions have been formulated. For instance in 1984 the WHO stated that health is not a state but a dynamic balance of resiliency, i.e. a resource for living. This revised version, which is still used today, defines health as the extent to which an individual or group is able to realize aspirations, satisfy needs and change or cope with the environment (WHO, 2018). Religion, spirituality or pursuit of meaning are not explicitly mentioned, but are probably implicit in keywords such as resilience, aspirations, needs and coping. However, in 2001 WHO acknowledged how difficult it is to understand mental health and mental functioning, and that from a cross-cultural perspective it would be impossible to formulate an encompassing definition [41]. Apart from the definition, the WHO also developed measuring instruments for quality in which the religious domain was indeed included [42].

Since then, attempts have been made to arrive at a new definition that includes spiritual and existential themes as a dimension of health (for an example) [43]. This is of course an important theme in the public domain. Health is not a goal as such, but a means to have meaningful goals and achieve a meaningful existence; it affects us all. Religion, spirituality and existential orientation are sources of support that enable coping in circumstances that are difficult to bear and to deal with.

In this regard, in its 2017–2020 action plan the WPA formulated important strategies to promote mental health and to improve the accessibility and quality of mental health care [31]. The action plan is based on three principles: the significance of mental health

and mental health care for specific target groups, the promotion of enabling activities, and collaboration with partners [31]. According to this action plan, psychiatrists — based on their expertise — should contribute to the promotion of mental health care and the improvement of mental health. It has become clear from the above that religion and spirituality can also contribute to improving mental health and personal recovery, and can therefore be part of health advocacy.

In this context, I want to cite two striking — and possibly unexpected — examples of health advocacy: promoting human flourishing [44], and defining forgiveness as a public health issue [45]. Firstly, human flourishing involves more than just psychological well-being. People can flourish even when they are living with mental illness. Personal recovery is more than just alleviating symptoms. Secondly, forgiveness is a powerful intervention that enhances health and wholeness, even on national and international scale. That is why flourishing and forgiveness are important for public health. Is that asking too much of psychiatrists? Again, it is about raising awareness of what serves mental health in terms of personal recovery.

CONCLUSION

Based on the foregoing discussion, it can be stated that a position statement is intended to increase awareness of the importance of religion and spirituality in psychiatry. One can excel as a psychiatrist or mental health professional by understanding the patient as a person in their uniqueness, with that unique person at the centre of attention.

The approval and publication of the Position Statement on Religion and Spirituality in Psychiatry is an important step in this regard. Not so long ago, the relationship between psychiatry and religion was one of bitter conflict. On the other hand, a dualistic position with watertight partitions between psychiatry and religion, each of which has its own domain, is equally disturbing (based on the typology of Barbour) [46].

The challenge that the Position Statement aims to address is that of the dialogue about presuppositions, assumptions, human vision and values in relation to the interpretation and application of empirically acquired data. The main dialogue is that between patient and psychiatrist (and other mental health professionals) and all other interested parties. The Position Statement clearly emphasizes this dialogue.

The acceptance of the Position Statement is an important step. This also underlines the fact that there is still a lot of work to be done, not only in research, but also in education — i.e. psychiatric training — and in continuing education and training.

In the meantime, a large international multidisciplinary network in psychiatry has developed that bridges cultural differences, and all over the world scientific and clinical work is being done to further develop our understanding of everything that has to do with the importance of religion, spirituality and pursuit of meaning for mental health and psychopathology. Indeed, religion, spirituality and pursuit of meaning have not become irrelevant, but are continuing to take on new forms of relevance.

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