SAMPLE CHAPTER FROM:

Spirituality and Psychiatry

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Spirituality in psychiatry

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Within British psychiatry, the notion of linking spirituality with psychiatry developed largely in the 21st century. What follows is the first attempt of the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists to put their heads together, metaphorically and constructively, and produce a book representing both their diverse views and shared vision for better psychiatric practice. Is the result a manifesto or a shopfront, a confession of our differences or a statement of our common beliefs? We will leave those questions with the reader.

Our first intended readership is the mental health community, including service users and carers, voluntary helpers and mental health professionals of all disciplines in the UK and overseas. Our secondary readership, we would hope, would be all those others who are interested in and concerned with mental illness. We share a belief that an aspiration towards the common good of improved mental health and treatment of mental illness in our communities is a worthy one, and that it is worth striving to turn this into a reality.

Spirituality, including its psychological aspects, is relevant for all psychiatrists, not as an add-on to our already overcrowded curriculum but as an idea 'at the back of one's mind', sometimes coming further forward. It is not to be forgotten, permeating every part of psychiatry and forming the underlying worldview from which one practises. If the psychiatrist remembers to incorporate spiritual values into his or her clinical practice, he or she will need to ask the patient a few pertinent questions, thus taking a spiritual history that assesses needs in this area.

How has spirituality entered psychiatry?

Historically, much psychiatric care has been provided within a spiritual or religious context. In medieval Europe, the shrines of St Mathurin and St Acairius in France or St Dymphna in Flanders held a particular reputation for miraculous cures of people with mental illness. In 1247 the priory of St Mary of Bethlehem was founded in Kent, England, for the care of the insane.

Bethlehem Hospital, later known as Bedlam and now as Bethlem Royal Hospital, is the oldest hospital in the UK for people with mental illness. In the Middle Ages, what little care there was for physical diseases like leprosy was provided by religious houses. Thus, the scene was set for the treatment of mental illness also to develop in cooperation with the Church. The Spanish Renaissance philosopher, Juan Luis Vives, contemporary with Erasmus and Thomas More, gave considerable attention to the humane treatment of people with mental illness, recognising them as suffering from illness and treating them with respect, as human beings. However, Vives, like other Renaissance thinkers and later also Galileo, despite being a devout Christian, came into conflict with the monolithic and inflexible ecclesiastical establishment. This conflict between those regarding madness as illness and Church orthodoxy worsened with the era of witch hunts in the 15th, 16th and 17th centuries.

Sadly, Bethlehem Hospital later became the notorious Bedlam, but in response to the inhumanities that arose there and elsewhere, the so-called 'moral approach' to the care of the insane was to bring about a revolution in care for the mentally ill. In late 18th-century England, this movement was led by William Tuke, a Quaker, who established the Retreat at York for the humane care of people with mental disorders.

Psychiatry as a distinct discipline starts at the beginning of the 19th century. Philippe Pinel wrote in 1801:

> As one takes up mental alienation as a separate object of investigation, it would be making a bad choice indeed to start a vague discussion of the seat of reason and on the nature of its diverse aberrations; nothing is more obscure and impenetrable. But if one wisely confines one's self to the study of the distinctive characteristics which manifest themselves by outward signs and if one adopts as a principle only a consideration of the results of enlightened experience, only then does one enter a path which is generally followed by natural history [Pinel, reprinted 1941: pp. 187–188].

There were remarkable developments in brain localisation and neurohistology during the 19th century in Germany. Wilhelm Griesinger regarded 'mental illnesses' as 'illnesses of the nerves and brain' (1867). The contribution of German psychiatrists to psychiatry, neuropathology and especially to classification, was immense and many of these 19th-century German pioneers remain household names within medicine. However, at the interface of religion and psychiatry, these discoveries had encouraged an attitude of reductionism.

Meanwhile, French psychiatry had reached reductionism by a different route – complex behaviour was thought to occur as a result of unconscious mechanisms, ultimately influenced by the state of the brain. Jean-Martin Charcot's pupil, Pierre Janet, psychologist and neurologist, had established the beginnings of psychotherapy by the end of the 19th century. Religion and faith were not seen as necessary in the equation for explaining human activity.

In Britain, following Charles Darwin's *Origin of the Species* (published in 1859), the concepts of 'natural selection' and 'survival of the fittest' had profound consequences for the care of the mentally ill. In part this was due to the subsequent interest in 'somatology', which discounted everything about man, including his history and personality, that could not be shown to be clearly organic. Another negative influence on treatment arose from the hypothesis of 'degeneration': all psychiatric illness was considered to be inherited and to become more severe in later generations. This ushered in several decades of therapeutic nihilism in psychiatry in Britain and elsewhere, which inhibited the search for new, effective methods of treatment.

By the middle of the 20th century, with science dedicated to material realism and with the arrival of modernism in philosophy, reductionism had come to dominate medicine. Man was 'nothing but' an excessively cerebral erect ape; human behaviour was 'nothing but' Pavlovian conditional or Skinnerian operant conditioned responses. Sigmund Freud had asserted that belief in a single God was delusional and that all religion is a mass neurosis. Psychoanalysis was in conflict with traditional religious attitudes and many churches identified Freud, psychoanalysis and by association the whole of psychiatry, with atheism, antagonism to religion and a challenge to conventional morality.

By the 1960s, there was no sense that the patient's religious beliefs contributed significantly to the psychiatric history, formulation or planning of treatment, and spiritual aspects of the patient's mental health problem were usually ignored. In the standard British textbook of the time (*Clinical Psychiatry*, Mayer-Gross *et al*, first edition 1954, later editions in 1960 and 1969) there are only two references to religion in the index, and it is assumed to be for 'the hesitant, the guilt-ridden, the excessively timid, those lacking clear convictions with which to face life'. During the 1970s more practising Christians began to come into the specialty in the UK and there was also a considerable influx into psychiatry of those from other faiths, most of whom had qualified in medicine overseas. The Scientific and Medical Network was set up in 1974, encouraging the exploration of the interface between spirituality, consciousness and mind.

During the 1980s, like-minded people got together and discussed non-material, religious and spiritual issues. Psychiatrists with spiritual interests gained confidence in expressing their faith and working out the consequences for their professional practice. Religious belief was still not regarded as respectable by the rest of the profession but there was less animosity. The quiet progress of the 1970s and 1980s became more public in the 1990s – in 1991, the Patron of the Royal College of Psychiatrists, His Royal Highness the Prince of Wales, urged an approach to mental healthcare that encompassed body, mind and spirit. Successive presidents of the College (Professor Andrew Sims and Professor John Cox) took up the subject in their addresses at College meetings in 1993 and 2002; a series of conferences on religion and psychiatry was held at the Institute

of Psychiatry in London. In 1994, the newly published revision of the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM–IV) included for the first time a category of 'religious or spiritual problem'. In 1997, the Archbishop of Canterbury addressed a joint annual meeting of the Royal College of Psychiatrists and the Association of European Psychiatrists.

Attitudes of psychiatrists changed significantly and psychiatry, as a profession, has become more accepting of the spiritual and religious concerns of patients and more interested in the relationship between psychiatry and religion. Research in the area of mental illness and religious belief developed during the 1990s from almost none to an accepted area of enquiry with research funding. Correspondingly, publications on spirituality in the psychological and healthcare literature increased exponentially (Cook, 2004*a*). The setting up of the Spirituality and Psychiatry Special Interest Group within the Royal College of Psychiatrists at the beginning of the new millennium was the culmination of a half-century of hard-won progress.

What is spirituality?

Spirituality and religion have overlapping but distinctively different meanings that have changed in recent decades, particularly in the case of spirituality. There are many possible definitions of spirituality, but for this book and its specific relevance for psychiatry, we have provided the authors with the following working definition of spirituality as a starting point:

> 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*a*: pp. 548–549].

This definition was developed from a study of the way in which the concept of spirituality is used in the literature on addiction and spirituality but it arguably applies equally well to other areas of psychiatry. It emphasises the universality of spirituality as a subjective dimension of the experience of being human, at the same time attempting to recognise that this is still, nonetheless, a socially situated phenomenon.

Religion is also susceptible to widely varying definitions – some emphasise the personal and others the social, some emphasise belief and others behaviour, some emphasise tradition and others function, and so on (Bowker, 1997: p. xv). The word religion has the same root as ligament, ligature and oblige. It is that grounding of faith and basis of life to which one regards oneself as being bound for one's survival, a rope that ties one

to God[1] and to other believers. For our purpose, it might be helpful to emphasise that religion is concerned with socially and traditionally shared beliefs and experience, but in placing this emphasis we must not lose sight of its personal and subjective dimension.

The word religion does not feature in the indices of most psychiatric textbooks. When referred to at all in hospital, it usually alludes to which denomination, if any, is favoured by the patient, like one's preferred supermarket. In everyday conversation, spirituality might be perceived as more inclusive of the large number of people in our society who profess no traditional religious affiliation. However, unlike religion, spirituality *per se* does not confer the support of a like-minded faith community that can offer social help and encouragement during life crises. The position, at least in the UK, is that when discussing such issues within the medical profession, the word spiritual may be preferable; the word religious carries too much historical baggage. Moreover, religion, despite the majority of believers of all creeds living peacefully, has recently yet again become associated with fanaticism and violence.

For research purposes, it has not proved possible to separate distinct factors of spirituality from religion in patient populations and so most studies are concerned with religious groups and their particular characteristics.

Before returning to our theme of the relationship between spirituality and psychiatry, it is important to give attention to one further concept of relevance to spirituality, religion and psychiatry – mysticism. Mysticism and mystical experience are touched upon in several chapters of this book, and such experiences can be easily misdiagnosed as psychiatric disorders (Cook, 2004*b*). Mysticism might be considered as a particular, perhaps extreme, manifestation of spirituality. However, it is also frequently (although not always) understood within a religious context. Like spirituality, it is receptive of diverse definitions.

In his *Gifford Lectures* (1901–1902), William James proposed four 'marks' of mystical experience: ineffability, noetic quality, transiency and passivity (James, 1902, reprinted 1985). In common with others, he understood mystical experience as being concerned with relationship with a transcendent, or 'ultimate', reality. This relationship has sometimes been understood in a very individualistic way, emphasising the personal and subjective nature of the experience, but in fact mysticism is concerned with experiences of the relationship of an individual with both a transcendent reality and a community (often, but not always, a community of faith). Stace (1973) has further suggested that mystical states may be 'introvertive' (looking inwards, into the mind) or 'extrovertive' (looking outwards), but he concludes that both types of mystical states are expressions of a fundamental experience of the unity of all things.

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1   We are mindful, however, that Buddhism traditionally does not assert the existence of God and that religion therefore does not necessarily entail belief in God.

A coalition of like-minded psychiatrists

The Spirituality and Psychiatry Special Interest Group was inaugurated on the cusp of the millennium. Why was it worth instituting and what has it set out to achieve? The Group answers:

> The Special Interest Group was founded in 1999 to provide a forum for psychiatrists to explore the influence of the major religions, which shape the cultural values and aspirations of psychiatrist and patient alike. The spiritual aspirations of persons not identifying with any one particular faith are held to be of no less importance, as well as the viewpoint of those who hold that spirituality is independent of religion. The meetings are designed to enable colleagues to investigate and share without fear of censure the relevance of spirituality to clinical practice. The Special Interest Group aims to contribute a framework of ideas of general interest to the College, stimulating discussion and promoting an integrative approach to mental healthcare. For patients, there is the need to help the service user feel supported in being able to bring spiritual concerns to the fore (www.rcpsych.ac.uk/college/specialinterestgroups/spirituality.aspx).

From its inception, the Spirituality and Psychiatry Special Interest Group has been a coalition of like-minded people, coming from different religious, spiritual and cultural backgrounds but with a shared aspiration. We hold in common a conviction that 'spirituality', whatever it may precisely mean, is immensely important and requires due consideration for patients and ourselves; it should permeate almost every area of psychiatric practice. It has been important to accept, respect and learn from our differences and never to devalue each other. Admittedly, 'Religion can be a source of discord. It can also be a form of conflict resolution … we need to search – each faith in its own way – for a way of living with, and acknowledging the integrity of, those who are not of our faith' (Sacks, 2002).

This diversity of interest and background is shown in the very wide range of topics discussed at the first 20 Spirituality and Psychiatry Special Interest Group one-day programmes (see p. xvii).

Spirituality of patients

As over two-thirds of the UK population have a stated religion, the notion that UK society is secular is clearly incorrect; the UK is, indeed, a multi-faith society but for 93% of those with a stated religion this is Christianity (Table 1.1).

In contrast with the general population, only a minority of psychiatrists in Britain hold religious beliefs: 73% of psychiatrists reported no religious affiliation as compared with 38% of their patients, and 78% attended religious services less than once a month (Neeleman & King, 1993). Only 39% of female and 19% of male psychiatrists believed in God. However, 92% of psychiatrists in Britain believed that religion and mental illness were connected and that religious issues should be addressed in treatment; 42%

Table 1.1   Religious affiliation of the UK population (Office for National Statistics, 2001)

Denomination	Followers, *n* (thousands)	%
Christian	42079	71.6
Muslim	1591	2.7
Hindu	559	1.0
Sikh	336	0.6
Jewish	267	0.5
Buddhist	152	0.3
Other religions	179	0.3
All religions	45163	76.8
No religion	9104	15.5
Not stated	4289	7.3
No religion/not stated	13626	23.2
Total	58789	100

considered that religiousness could lead to mental illness, but 58% never made referrals to clergy. There is, therefore, a marked disparity between patients and their psychiatrists in terms of their religious belief and its implications for daily life.

It is unlikely that a psychiatrist will share his or her culture and religion completely with any individual patient. This can be beneficial to the patient, as the relationship will be less influenced by unconscious pressures. This is true not only where the patient comes from a minority ethnic and religious group and is treated by a White, British born and trained psychiatrist. The majority Christian religious group is not a single community but comprises many subgroups with quite extreme differences, especially in religious expression. Take, for example, the difference between a suburban London Pentecostal church and its members and a rural, village community clustered around its parish church. It follows that the psychiatrist who aspires to be sensitive about spirituality and religion also needs to be aware of culture differences.

Psychiatrists also need to be sensitive about genre, defined as the way language is organised to achieve social processes.

> Just as the genre of a mystery story has components of introduction of characters, inciting event, search for clues and the villain, discovery of villain, denouement, etc., so the genre that accomplishes a social process (e.g. a casual conversation that continues and solidifies a friendship) may have elements such as *greeting, approach to neutral topics like weather, approach to a substantive topic (why we are having this meeting), leave taking* [emphasis ours]. Such elements establish a schematic structure that speakers are expected to be familiar with [Fine, 2006: p. 307].

The importance of genre, in addition to culture, in any exchange between patient and doctor concerning belief, faith and spirituality cannot be overemphasised.

Religion is a protective factor from and in mental illness. The work demonstrating this is drawn together in the *Handbook of Religion and Health* (Koenig *et al*, 2001). This cites 1200 original research studies and 400 reviews, with chapters on both physical and mental health. In most of these studies, 'religious practice or belief' was added as incidental to the main study. This is, methodologically, a strength in that it shows that research was carried out without positive or negative religious bias. Looking at various factors relevant for mental health, religious involvement was found to be significantly correlated with:

- well-being, happiness and life satisfaction
- hope and optimism
- purpose and meaning in life
- higher self-esteem
- bereavement adaptation
- greater social support and less loneliness
- lower rates of depression and faster recovery from depression
- lower rates of suicide and fewer positive attitudes towards suicide
- less anxiety
- less psychosis and fewer psychotic tendencies
- lower rates of alcohol and drug use and abuse
- less delinquency and criminal activity
- greater marital stability.

Religion can also have negative effects on mental health; in their handbook, Koenig *et al* identify three groups of these (pp. 227–228):

1 Adverse effects on number and type of stressful experiences, due usually to excessive devotion to religious practices and consequent neglect of other responsibilities, or rigid interpretations of scripture which lead to abusive behaviour of others.

2 Adverse effects on attitudes and cognitive thought processes, including rigid and legalistic thinking, excessive guilt, stigmatisation of those whose religious beliefs differ, judgementalism, and justification or concealing of pathological or otherwise maladaptive thoughts, attitudes and behaviours.

3 Impaired coping behaviour, including, notably, failure to seek appropriate medical help owing to inappropriate reliance on religious rituals or counsel.

However, in general, the beneficial effects considerably outweigh the adverse ones. Koenig *et al* explain this in terms of the bio-psychosocial model of psychiatric illness (2001: pp. 222–228).

The conventional wisdom of psychiatry in the past was that people with mental illness were timid, easily influenced and dependent upon others. This has been challenged by work on religious belief and locus of control (Jackson & Coursey, 1988). Many patients consider that they are incapable

of independent action and controlled by outside circumstances; these are said to have an external locus of control. In the research on this topic, a sense of personal control (or a degree of perceived choice) is a strong predictor of a subjective feeling of happiness. Although believing that God is 'in control' might appear to suggest an external locus of control, research studies have shown a significant, positive relationship between religious belief and internal locus of control. Critics of religion claim that the person believes him- or herself to be controlled from outside by God or another force, but this is not the case. Those with a religious faith are arguably more independent as individuals and more able to make life decisions, knowing that God is 'with them'.

Spirituality of psychiatrists

The psychiatrists need to have clear aims and aspirations for the treatment of each individual patient. In order to benefit the patient, the psychiatrist is required to listen empathically; and inevitably, he or she has values and standards that are applied, often unconsciously, in clinical practice. There has been much work on values in psychiatry over recent years, much of it pioneered by the Royal College of Psychiatrists Philosophy Special Interest Group and its founding chairman (Fulford *et al*, 2006: part IV).

There has been concern in medicine generally, and psychiatry specifically, about burnout in doctors. Following the inception of the National Health Service (NHS), psychiatrists were able to retire earlier than other consultants through entitlement to Mental Health Officer status. Many took this option and retired from the NHS early, from the age 55 onwards (this employment option has recently been withdrawn). Many have felt exhausted, jaded, worn out and undervalued, no longer had the zest for their work or were not able professionally to continue any longer. For some, renewing their interest in spirituality and/or religious belief in relation to psychiatry at this time has been valuable in approaching their work with fresh vigour.

We now have more information on professional burnout and the health of doctors. Psychiatrists, when compared with other doctors, are more likely to suffer from burnout (Kumar *et al*, 2005), have higher reported rates for depression (Deary *et al*, 1996) and show higher suicide rates (Hawton *et al*, 2001). Methods of dealing with this have concentrated on career counselling, selection for the specialty, training and continuing professional development, recruitment, and having effective systems in place for recognising when things go wrong (Firth-Cozens, 2007). All psychiatrists should be trained to help colleagues with mental health problems, both within psychiatry and in other medical disciplines.

Some psychiatrists, especially as they become more senior in their work, gradually develop existential or spiritual difficulties concerning their professional practice. If they cannot resolve these concerns and deal with their internal doubts, they become more prone to burnout and

despondency. An involvement in religious belief and practice or in some type of spirituality is valuable for preventing such existential despair.

Being able to acknowledge one's spiritual being gives a sense of fulfilment which facilitates coping with the stresses of professional life. Since its inception, the Spirituality and Psychiatry Group has clearly met a previously unrecognised need of psychiatrists, as the membership figures show (by 2007, out of a College membership of 13 000 members and fellows, the Group had attracted more than 1500 members, nearly 12% of the College membership). At an early meeting of the Spirituality and Psychiatry Group, an elderly psychiatrist said, with considerable emotion, 'All my working life I have wanted something like this, where I could discuss these issues with my colleagues'. Many of us had felt constrained by the rigid template imposed by the psychiatric establishment, which had excluded from consideration spiritual aspects of either the patient or the psychiatrist. Previously, such matters had not been discussed either with patients or in any professional forum.

Spirituality in psychiatric treatment

Spirituality is increasingly being included as a component of psychiatric treatment and also as an independent and dependent variable in treatment research. Furthermore, a variety of faith-based organisations are providing care for people with mental health problems (Koenig, 2005). Koenig proposed ten ways in which religion can improve mental health (2005: pp. 133–139). He includes within his analysis reference to spiritual as well as religious beliefs and we would extend the analysis here to explicitly refer to both throughout. Thus spirituality and religion:

1   Promote a positive worldview.
2   Help to make sense of difficult situations.
3   Give purpose and meaning.
4   Discourage maladaptive coping.
5   Enhance social support.
6   Promote 'other-directedness'.
7   Help to release the need for control.
8   Provide and encourage forgiveness.
9   Encourage thankfulness.
10   Provide hope.

Like Koenig, we recognise that spirituality and religion can also be deleterious to treatment and such pathological forms of spirituality are discussed later in this book (chapter 13). However, psychotherapy and counselling based upon religious frameworks of belief or else offered within the context of a faith community, can bring great benefit when undertaken within proper professional and ethical boundaries and appropriately offered. It is also possible to explore spirituality in the secular treatment setting and organisations like Alcoholics Anonymous explicitly adopt a

'secular spirituality', which is open to people of all faith traditions or none (this will be considered further chapter 8).

Furthering spirituality in mental healthcare in the UK

Historically, people with widely different and strongly held beliefs have not always proved to be natural allies. The strength of the Spirituality and Psychiatry Special Interest Group is that it is a coalition built on mutual respect for each person's beliefs and traditions. The problem with coalitions, whether political or ideological, is that those with strong convictions find it hard to collaborate with others coming from a different ideology. To overcome this barrier to progress, we have had to respect the beliefs of those from different faiths, as well as those not aligned with a faith tradition, recognising that we can make headway together in a way that would not be possible as individuals. It is essential that all those for whom religious and spiritual aspects of psychiatry are important feel able to join and contribute towards the work of the Group. Tolerance and valuing different perspectives has been crucial, an ethos that so far the Group has been able to maintain well.

The Royal College of Psychiatrists needs to produce expert and well-balanced material and opinion from its component parts. In this, the Spirituality and Psychiatry Group has a continuing role and does make comment where appropriate. This book aims to be such a contribution. To fulfil what is expected of us, we need to be aware of the existing spiritual and religious dialogue on each issue of concern, ascribing sources where relevant, taking into account scientific evidence, giving rational argument for our statements and, above all, representing a high standard of psychiatric knowledge and practice. We should also avoid evanescent sensationalism. Only if all these criteria are achieved have we any right to expect others to listen to us and act upon our recommendations; only then can our contribution to professional discourse become an acceptable and valid position, even if not universally agreed.

The Spirituality and Psychiatry Group will have to develop intellectual muscle for its continuing existence and influence. It will need to convince psychiatrists that they, as well as their patients, have emotions. It will need to demonstrate the volitional nature of humankind and remind us that we are not wholly determined in our thought and behaviour by biochemistry and circumstances.

Mental health statutory and voluntary organisations have become much more aware in recent years of the spiritual aspirations of patients and professional staff. The Spirituality and Psychiatry Group will continue to make a contribution to this debate in various different ways; it is increasingly seen as a source for expertise and advice at the interface between spirituality and psychiatric practice. Members of the Group have formed useful links with religious organisations such as churches, mosques

and synagogues, and with clergy, especially hospital chaplains or equivalent designations (e.g. spiritual advisors). In the past, relationships were often strained between the two institutions of psychiatry and the Church, but easier communication in recent years has been immensely beneficial to psychiatric patients and their relatives. By drawing on the insights of both institutions, we have aimed to help our patients, to improve training and continuing professional development and to expand the vision of religious ministers and mental health professionals alike. It is important that this is not just the cosy situation of a psychiatrist of one religious persuasion conferring with a like-minded religious leader. Our diversity is a positive contribution we can make and it is necessary for our patients to have confidence in us.

The Spirituality and Psychiatry Special Interest Group has therefore a useful role in giving helpful direction and advice to the College and through the College to other mental health individuals and organisations of users, carers, volunteers and professionals. A specific example of this is planning the training of psychiatrists and other doctors in psychiatry, and also the continuing professional development of trained doctors. The Group has already contributed to this and intends to continue to do so through proposals for the curriculum for professional postgraduate examinations and training, commenting on the required characteristics of trainees and trainers and the interaction between them, and on the accreditation of psychiatric training schemes.

Training in spirituality and psychiatry

In order to introduce spiritual aspects into the training of psychiatrists, we need to help trainees to overcome common prejudices such as 'religion is usually harmful for patients' and 'religion is for the weak, vacillating and dependent'. Training concerning spirituality and psychiatry should consider what is relevant in terms of knowledge, skills and attitudes. In addition, it is important to consider clinical judgement, which is itself a neglected matter associated with the spiritual value of discernment.

We need to look at each level of training for psychiatry: medical undergraduate, postgraduate psychiatrist in training and continuing professional development for the fully trained psychiatrist. Taking a religious or spiritual history should be emphasised; the following example is drawn from the American College of Physicians (Lo *et al*, 1999):

1   Is faith (religion, spirituality) important to you in this illness?
2   Has faith (religion, spirituality) been important to you at other times in your life?
3   Do you have someone to talk to about religious/spiritual matters?
4   Would you like to explore religious/spiritual matters with someone?

Such questions need take very little time, perhaps only a couple of minutes (Koenig, 2004). In more expanded form they might lead on

to discussions about whether religious/spiritual beliefs are supportive, anxiety provoking or punitive; whether the patient is a member of any spiritual/religious community; what the patient's relationship with clergy is like; whether there are any spiritual/religious issues the patient would like to discuss in therapy; whether the patient's spiritual/religious beliefs influence the type of therapy he or she would be most at ease with; and how his or her beliefs influence their attitude to medication.

Other concerns to be addressed in the curriculum might include:

- psychiatrist's awareness of and responsiveness to:
    - the need to find a sense of meaning and purpose in life
    - the personal search for answers to deeper questions concerning birth, life and death
    - the difference between spirituality and religion, and their inter-relatedness
    - the relationship of spirituality to the development and expression of individual human values
    - how spirituality informs concepts of good and evil
    - the way in which good medical practice is founded on values that include discernment, compassion, generosity, tolerance, patience, honesty, humility and wisdom
    - the psychiatrist's own value systems and the way that these may influence others
    - the value systems of others and the psychiatrist's own response to these;
- knowledge of:
    - spiritual development as part of personal growth
    - spiritual crises, meditation, prayer and altered states of consciousness, including the near-death experience
    - the spiritual significance of anxiety, doubt, guilt and shame
    - the spiritual importance of love, altruism and forgiveness and their relation to mental health
    - the influence of materialistic goals on personal identity and self-esteem
    - the reciprocal relationship between culture and spiritual/religious beliefs and practices and their consequences for psychiatric practice
    - how the presence or absence of spiritual/religious beliefs and practices in mental healthcare workers may influence clinical decision-making
    - the role in clinical management of spiritual/religious support networks, including chaplaincy and pastoral care departments as well as those in the community
    - quantitative and qualitative research on spirituality and mental health;
- skills in:
    - taking a spiritual history

- being able to stay mentally focused in the present, remaining alert and attentive with equanimity
- developing the capacity to witness and endure distress while sustaining an attitude of hope
- the recognition of his ot her own emotional responses to spiritual disclosures
- honest self-appraisal, in the interest of continuing personal development
- maintaining personal well-being in the interest of patient care.

Conclusion

Psychiatrists and other mental health professionals need to be bilingual, 'fluent in … the language of psychiatry and psychology … and the language of spirituality that focuses on issues of meaning, hope, value, connectedness and transcendence' (Swinton, 2001: p. 174). It is probably fair to say that we have, for too long, neglected one of these languages to our own detriment and the detriment of our patients. That there is now renewed interest in learning the language of spirituality is very encouraging, but like all languages this one needs practice. Just as the language of psychiatry needs to be employed at every stage of assessment, diagnosis and treatment, as well as in all good research and training in mental healthcare, so the language of spirituality needs to permeate our relationships with our patients, colleagues and our whole understanding of the field of psychiatry.

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