The sacred versus the secular in UK psychiatry

Poole, Rob

BJPsych Advances

DOI:
10.1192/bja.2020.32

Published: 25/08/2020

Peer reviewed version

The sacred versus the secular in UK psychiatry:
A commentary on Religion and Psychiatry

Koenig and colleagues present two connected review papers on religion and psychiatry. The first is a selective summary of research. The second makes recommendations for clinical practice. Professor Koenig provoked controversy in 2008 with a paper on similar themes in the Psychiatric Bulletin (Koenig 2008), advocating integration of so called 'religion/spirituality' into clinical practice. In my opinion, these new papers are best seen in the context of the continuing debate within UK psychiatry (Poole et al., 2019).

There are some uncontroversial points here: patients' faith should be treated with respect as an important part of their lives; religion can be both helpful and unhelpful to mental health; understanding the relationship between symptoms and religious beliefs is sometimes important; and it is legitimate for psychiatrists to work alongside chaplains and other religious leaders. I teach these points to medical students, just as I was taught them in the 1970s. Other aspects of the article are more contentious.

As is commonly the case from advocates of the integration of religion into clinical practice, the articles start with assertions that psychiatry has generally regarded religion as intrinsically pathological. I see little evidence that this is correct, even taking into account the citations here. However, what has worried sceptical clinicians about the growing literature of psychiatry and religion has been lack of clarity about relevant professional boundaries (Poole & Higgo 2011).

There are gaps in the overview of research on religion and mental health, the most obvious being the omission of some major public concerns. Amongst these is the effect on mental health, short- and long-term, of child sex abuse perpetrated by priests and other religious figures in the context of their religious role (Lueger-Schuster et al., 2014), often facilitated or covered up by religious authorities (Death, 2015). This has proven to be so serious and widespread that it has led to major change in the status of religious authority all over the world, especially the Roman Catholic church. Similarly, there is nothing here about unequivocally harmful religious counselling, such as sexual orientation conversion therapy. This has been condemned as ineffective and unethical by the Royal College of Psychiatrists (RCPsych 2014), but is still advocated and practiced by some Christians in the UK (Christian Concern 2018). These omissions do not invalidate Koenig and colleagues' papers, but they do mean that they lack balance between the benefits and harms of religion.

Like most recommendations for clinical practice, Koenig and colleagues clinical guidance is based more on opinion than evidence. The statement in the first paper that "such studies…..have the potential to contribute evidence for causation" is appropriately cautious, as the totality of the evidence does not remotely meet the Bradford Hill criteria (Bradford Hill, 1965). Their clinical guidance, however, is implicitly based upon an assumption of causality. This is not an obscure technical point. Much of the literature concerns Christians in the USA, who are the majority in the most religiously active of high income countries. Religion is a social as well as a spiritual phenomenon, closely linked to ethnicity and class. These are potential confounding factors in most studies. Furthermore, in culturally diverse

societies like the UK, religion has many implications relating to power imbalances and to misuses of power. For example, patients belonging to Muslim minorities might reasonably feel nervous about discussion of their faith with non-Muslim psychiatrists, given prevalent levels of Islamophobia in the UK and USA. These concerns are highly salient to clinical practice, and it is a shame that there is no guidance here about how they might be tackled in practice. In my opinion, the clinical recommendations are not of universal applicability.

In the Clinical Applications paper, the authors' correctly state that there is little controversy over holistic care that takes into account the patient's religion, where this is the patient's wish. However, I am less comfortable about the related assertion that implies that mental health professionals should assume that religion is benign and beneficial. Both the full literature and experience shows that even amongst the devout, religion can be more ambiguous than this. The authors do make reference to problems caused by religion, but this is mainly described as "how clients may use religion neurotically". It seems possible that sometimes the problem can be with religion and not the patient. It is right that psychiatrists should not seek to undermine their patients' faith, but, in my opinion, they should also be careful not to make assumptions about it.

The Clinical Applications paper makes reference to moral injury, a problem that has become topical with regard to decisions that health professionals have to make in coping with the coronavirus pandemic. They make reference to Spiritually Informed Cognitive Processing Therapy, a novel intervention for moral injury in the context of post traumatic stress disorder (PTSD) that is under evaluation (Pearce et al., 2018). This has been developed on the basis of the observation that moral injury and 'spiritual struggles' make it difficult to recover from PTSD and that US military personnel and veterans report high levels of religion/spirituality. I do not criticise the development of explicitly religious forms of therapy, but they are culture bound and therefore not necessarily generally applicable. Many people in the UK do not derive their morality from organised religion and, in any case, it is not clear that moral injury is best understood as a psychiatric disorder per se. Most importantly, a request for a religion- or spirituality-informed therapy does not absolve the therapist of responsibility to be vigilant for inadvertent violations of boundaries.

Few areas of psychiatry are immune from a mismatch between rhetoric and evidence. In the case of religion, I would be less concerned if it were not for persistent recommendations to change the boundaries of professional practice in a way that I and others believe to be inappropriate. This long debate appears to be far from over and readers will make up their own minds about the salience and validity of these contributions.

Declaration of competing interests

I am an atheist

Author

Rob Poole MB BS, FRCPsych
Professor of Social Psychiatry

Centre for Mental Health and Society
Bangor University
Wales, UK

r.poole@bangor.ac.uk

Author Biography

After 21 years as a NHS psychiatrist, I became an academic in 2009. My current interests include self-harm, prescribed opioids and professional boundaries violations. I have co-authored four books, on clinical skills and on social determinants of mental health. I was awarded the RCPsych Lifetime Achievement Award 2017.

References

Bradford Hill A (1965) The environment and disease: association or causation?" Proceedings of the Royal Society of Medicine, 58, 295-300 doi: 10.1177/00359157650580050

Christian Concern (2018) Ten reasons not to restrict same-sex attraction therapy. London: Christian Concern https://christianconcern.com/comment/ten-reasons-not-to-restrict-same-sex-attraction-therapy (accessed 27th February 2020)

Death J (2015) Bad apples, bad barrel: Exploring institutional responses to child sexual abuse by Catholic clergy in Australia. International Journal For Crime, Justice and Social Democracy 4(2): 94-110. doi:10.5204/ijcjsd.v3i2.229.

Koenig HG (2008) Religion and mental health: what should psychiatrists do? Psychiatric Bulletin 32 (6), 201-203 doi: https://doi.org/10.1192/pb.bp.108.019430

Lueger-Schuster B, Kantor V, Weindl D, Knefel M, Moy Y, Butollo A, Jaqsch R, Glück T (2014) Institutional abuse of children in the Austrian Catholic Church: Types of abuse and impact on adult survivors' current mental health. Child Abuse & Neglect 38(1): 52-64. doi: 10.1016/j.chiabu.2013.07.013.

Pearce M, Haynes K, Rivera N, Koenig H (2018) Spiritually Integrated Cognitive Processing Therapy: A new treatment for Post-traumatic stress disorder that targets moral injury Global Advances in Health and Medicine, 7, 1-7 doi https://doi.org/10.1177/2164956118759939

Poole R, Cook C, & Higgo, R. (2019). Psychiatrists, spirituality and religion. The British Journal of Psychiatry, 214(4), 181-182. doi: https://doi.org/10.1192/bjp.2018.241

Poole R, Higgo R (2011) Spirituality and the threat to therapeutic boundaries in psychiatric practice. Mental Health, Religion & Culture, 14:1, 19-29. doi: https://doi.org/10.1080/13674671003746845

Royal College of Psychiatrists (2014). Position statement on sexual orientation PS02/2014 London: Royal College of Psychiatrists. https://www.rcpsych.ac.uk/improving-

care/campaigning-for-better-mental-health-policy/position-statements/position-statements-2014?searchTerms=position%20statements (accessed 27th February 2020)