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Controversies and Consensus: A Matter of Attitude

Peter J. Verhagen

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Controversies and Consensus: A Matter of Attitude

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Psychiatry and Religion
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So liegt es tief begründet, daß der Arzt seinen Beruf nicht nur als Forscher oder Wissenschaftler versteht, aber auch nicht als ein bloßer Techniker, der die Wissenschaft und ihre Erkenntnisse für das "Gesundmachen" zur Anwendung bringt. Es ist ein Moment der Nähe zur Kunst darin, das nicht zu dem gehört, was man durch theoretische Belehrung vermitteln kann und das dem Namen Heilkunst entspricht.

Hans-Georg Gadamer (1993, p. 201)

International Series in Mental Health and Religion

4

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Most of the texts, with the exception of Chapter 1 and Chapter 9, have been published previously.

Chapter 1. General introduction
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Chapter 2. Religion, spirituality and psychiatry. A field wide open for discussion and research
Based on three previous publications:

a) Herman M. van Praag & Peter J. Verhagen, Religion, spirituality and psychiatry: A field wide open for discussion and research. In G.N. Christodoulou (Ed.), *Advances in Psychiatry: Second volume* (pp. 251-258). Athens: World Psychiatric Association, 2005.
b) Peter J. Verhagen & Herman M. van Praag, Religie, Spiritualiteit en psychiatrie: Een breed terrein voor discussie en onderzoek [Religion, spirituality and psychiatry: A Field Wide Open for Discussion and Research]. In T.I. Oei & M.S. Groenhuijsen (Eds.), *Capita selecta van de forensische psychiatrie anno 2006* [Capita selecta of forensic psychiatry anno 2006] (pp. 57-76). Deventer: Kluwer, 2006.
c) John L. Cox & Peter J. Verhagen, Spirituality, religion and psychopathology: Towards an integrative psychiatry [Special issue]. *International Journal of Person Centered Medicine*, 2011, 1(1), 146-148.

Chapter 3. The case for more effective relationships between psychiatry, religion and spirituality
Peter J. Verhagen, *Current Opinion in Psychiatry*, 2010, 23(6), 550-555.

Chapter 4. Psychiatry and religion: Values, research data and professionalism
Peter J. Verhagen, *Minerva Psichiatrica*, 2013, 54(2), 149-164.

Contents and authorship further specified

I would like to express my gratitude to the co-authors with whom I have worked over the years.

Chapter 2
In this chapter I used materials originally prepared and published by Van Praag, Cox and myself in order to raise awareness of the agenda and activities of the World Psychiatric Association Section on Religion, Spirituality and Psychiatry.

The order of authors reflects their role in the writing process. This means that I wrote the second article (b) (Van Praag commented on and corrected the various drafts), and that I commented on, completed and reformulated drafts of the first article (a). Cox invited me to contribute to and comment on the third article (c). I drafted the figure (Figure 1). During the preparation of this chapter, moreover, I revised, amended, and updated the previously published texts.

Chapter 6, Section 6.4
Regarding Section 6.4 the following should be noted. The WPA Position Statement is a policy document of an international organization. This implies that the order in the list of authors is determined by their respective roles in the organization (the WPA Section on Religion, Spirituality and Psychiatry) and not by the amount of work each of them devoted to the writing itself. The first three authors were, at the time of publication, the current chair, co-chair and secretary of the Section. As fourth author, I was the initiator of the project on behalf of the Section. The fifth author (Cook) actually wrote the text. The amount of effort each author has given to the project itself (not only the writing), is also not reflected in the order of appearance of the authors in the list of authors. Cook and Verhagen started working on the project in 2006, Cook participated on behalf of the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists in London, Verhagen participated as member of the board of the Section. A first version of

the statement was ready in 2008 and published in 2010. This text has been included as appendix to Section 6.1 (pp. 133-134). The other authors (the first three) became involved at a later stage during the process of developing the Position Statement.

Chapter 8

I am the first and main author of the complete article. Schreurs read, reviewed, and commented on the first draft. In this article, I used a model developed by Vincent Brümmer, emeritus professor of the philosophy of religion. Schreurs applied the model to spirituality and psychotherapy. My first aim was to make Brümmer's model on spiritual and interpersonal relationships better known in the scientific literature, especially in the field of psychology of religion. The second aim was to connect this model with the turn to relational spirituality in psychology of religion. I also wanted to start a dialogue, based on the model, about a new approach to personality disorders in the most recent classification of psychiatric disorders DSM-5™. I made thus three contributions to the model: heightening the awareness about Brümmer's model and its possible relevance, opening up a relatively unexplored research domain, and establishing a connection with a new development in psychiatry.

Chapter 1

General introduction

This thesis consists of a description of and reflection on the work that was done on behalf of the World Psychiatric Association (WPA) Section on Religion, Spirituality and Psychiatry to reach consensus on the role of religion in psychiatry. This search for consensus was driven by a number of questions and concerns. I mention the most important ones: Despite the evidence for positive and negative associations between religion and mental health, how is it possible that psychiatrists still seem to be reluctant to take these findings into account? How is it possible that in a specialty like psychiatry, in which evidence and evidence-based clinical work are so important, empirical evidence is neglected? Is this a blind spot of psychiatrists? Is it a matter of attitude? Is it a shortcoming of residency training and continuous medical education? Or is it a problem of the evidence itself, of its lack of quality, or applicability, and/or relevance? What is the role of the religiosity gap between psychiatrists and their patients? Do psychiatrists still adopt a critical attitude toward religion?

Questions like these pertain to two main concerns of this thesis: the dispute on the validity, applicability and relevance of the empirical findings and the (at best reluctant) attitude of psychiatrists and mental health professionals toward religion. Therefore, the review and discussion of the literature in this thesis will be focused on these two concerns. Our discussion will, besides this, be informed by the many discussions at WPA international conferences and board and other meetings.

During the whole process I found myself thinking about the role of fundamental attitudes with respect to the relationship between religion, science and clinical practice. I started to wonder whether it would be possible to formulate a position towards religion that would help to open-up previously closed views. I began to reflect on the broader

issue of how science relates to religion. How would it be possible to see them not as enemies or as independent from each other, but as partners in a mutual relationship of recognition and appreciation? Such a position, which I call a stance, would not represent a religious position but a way of relating of the psychiatrist to both science and religion, from the perspective of his or her profession. This stance refers, in other words, to the attitude of the psychiatrist toward the patient and his/her experiences, the clinical practice of diagnosis and treatment, the science of psychiatry, and the values, goals and views of life that pertain to the clinician and his or her profession. I will come back to this in the General discussion.

From the very start it was the intention to put religion and spirituality on the agenda of the WPA worldwide community. One of the main tasks of the WPA sections is to draw the attention of the psychiatric world to whatever is necessary for the development of the field. In that sense the creation of the Section was an initial, very important step, that was welcomed by the WPA. Its leadership supported the Section warmly. At the same it was clear that many others–colleagues, researchers and groups–had similar thoughts and comparable intentions. Very soon we started to collaborate with many colleagues around the world and especially with the *Spirituality and Psychiatry Special Interest Group* (SIG) of the *Royal College of Psychiatrists*.

In this thesis I report on what started as a "wish" and "intention", and what grew out to a major ambition of the Section. I soon discovered that an elegant and pragmatic way to work on the goal of getting religion and spirituality back on the agenda of psychiatry would be to formulate a position paper that, after having been accepted by the executive bodies of the WPA, could acquire the authority that is needed for a change in professional attitudes. After a long process of formulation and negotiation, this approach turned out to bear fruits: In 2016 a Position Statement was approved by the Executive Committee of the WPA.

Above I used the terms "wish" and "intention". Let me rephrase what I wrote in the leading question of this thesis: Would it be possible to achieve consensus on the relevance of religion (and spirituality) in psychiatry in the WPA worldwide community? What are the hindrances, the controversies? Above I mentioned several issues as

possible obstacles. Which of them are most influential? What could be done about them? And, most importantly, how should a consensus look like?

The wish and intentions expressed above and the ensuing developments in the WPA Section form the background of the questions that will guide us throughout this thesis: What are the conceptual, theoretical and clinical concerns that need to be addressed in order to establish a (preferably) worldwide consensus on the relevance of religion (and spirituality) in psychiatry? This is the overarching question. Subquestions are: How can common ground be gained in the discussion? What are the controversies? What are the obstacles, theoretically, practically and in terms of professional policies? How can these controversies and obstacles be assessed, addressed and solved? And, of course, what should, ideally, be the content of the consensus?

The papers that form the corpus of this thesis are results of the discussions in the Section and during the many symposia that it organized over the years. Papers are presented in chronological order in which these discussions took place. The thesis will close with a General discussion.

Why a mutual approach is needed

Before proceeding with the articles, I need to clarify my own take on the issue of how psychiatry and religion are related. Why this intention, this ambition? In fact this is an easy and at the same time very complicated question. Easy, because one could simply say that since the 1980s there has been growing, even abundant evidence that religion is important in relation to mental disorders and mental well-being. The question is also complicated, however. There are methodological discussions about the evidence itself. There are questions about its relevance for clinical practice. There is ignorance and even neglect by psychiatrists of the clear and uncontroversial evidence, piled-up over the last decades. There are also more fundamental discussions about how to conceptualize and explain the relationship between religion and psychiatry as well as between religion and mental health. A lot of research has been done on the topic of religious interventions and faith-

adapted therapies,[1] but the debate did not dwindle. Positive correlations between health indices and religious variables are well-established, but it is less clear what these correlations explain. Longitudinal studies are valuable and point at directions for explanations, but the opinions about these findings and their relevance are divided.

What complicates matters further are unresolved debates on the definition of religion (and spirituality), and the operationalization of these constructs, despite a proposal for consensus on this topic (King & Koenig, 2009). Notably, both psychiatry as a medical specialty and religious studies are very much multi-disciplinary fields of research. The science of psychiatry is a multidisciplinary mixture of medicine, genetics, biochemistry, neuroscience, behavioural sciences, ethics and law. This also holds for research into religion, which involves psychology of religion, sociology of religion, genetics, cognitive science of religion, cultural anthropology, theology and philosophy of religion. So it is not at all clear what is meant when we study the relationship between religion and psychiatry. Both are complicated and multi-faceted fields of inquiry. It will be difficult to combine them and develop a comprehensive picture of the many possible interactions and relations. As a result of this complexity it is difficult to assess the relevance of the evidence. This does not mean that there is no valuable evidence, but the results and their interpretations are mixed and, also, somewhat unclear at first sight. There is, for instance, overwhelming evidence for a positive correlation between many aspects of religion and a range of mental health indices and outcomes, but negative correlations and no correlations are reported as well. And, despite numerous proposals for the mechanisms that could explain these correlations, there is hardly anything firmly established with respect to possible causal relations (VanderWeele, 2017). Therefore, not only the nature of the evidence is at stake, but also (and equally) the interpretation of the evidence.

1 In 2010 the American Psychological Association's Task Force on Evidence-based Therapy Relationships concluded that "Adapting or tailoring the therapy relationship to specific patient characteristics (in addition to diagnosis) enhances the effectiveness of treatment". Incorporating religious beliefs and practices is one of the recommendations (Norcross & Wampold, 2011, pp. 423-424).

Four epistemic perspectives

In order to shed some light on the complexity of the field and the various approaches to it, I introduce a distinction between four epistemic perspectives: the perspective of everyday experience and knowing, the clinical perspective, the scientific perspective and the philosophical perspective.

The perspective of *daily, naive experience* refers to the basic intuition that all things are connected in some way, that they form a world and that I am part of this world. This does not mean that there are no interruptions, irregularities, tensions or ambiguities. On the contrary, brokenness and ambiguity are part of our everyday life. However, in the daily flow of events people nevertheless experience their existence as continuous and coherent. This flow is interrupted when people are confronted with events or experiences that disturb them and with which they cannot connect. Religion offers in a certain way answers and ways of coping with these disturbances and tensions and their senselessness. But, as I said, these interruptions, tensions, and disturbances should not detract from the fact that by default our everyday experience is characterized by a sense coherence and continuity. With the first epistemic perspective, I aim at this basic, intuitive way people understand their world and their existence as fundamentally coherent and continuous (Glas 1996; Verhagen, 2009, 2010).

When they talk to their psychiatrist, people talk about their daily experience. However, in this context of clinical practice something changes. We enter the *clinical level* of understanding. Probably the psychiatrist will take some time to listen to this common experience, but then he or she will start to look for symptoms and signs, regularities or disturbances in the patient's life, and factors that in one way or another influence their mental condition and functioning. And psychiatrists will formulate a diagnosis (or better a differential diagnosis) and they will propose a treatment plan. Compared to the perspective of daily experience, this obvious course of successive steps implies a form of abstraction. And it is very helpful and fosters a working alliance when the psychiatrist successfully explains what this clinical abstraction has to do with the experience of the patient. If the patient still asks "is that me?", this is not necessarily a sign of psychopathology or resistance.

Probably the psychiatrist needs to explain his or her analysis a bit better, or to use other words.

What if the patient asks something like: "How does this connect with my religious life?" Would that be a strange question? If so, why? If the patient would have asked: "What does this have to do with my sexual life, or my family life or my professional life?", would that be a strange question? And if not, what is the difference between these questions and the question about religious life? Anyhow, during abstraction from daily experience, aspects of that experience are lost. That is not a problem as such. The challenge is not to lose the important experiences and to be able, if necessary, to return to them and to listen carefully again.

Psychiatrists must be aware of the input of science for their profession, and they are trained to read and to evaluate scientific developments, findings, research data and opinions. Religion is one of the topics to be found in the literature. In other words, mental health professionals, especially psychiatrists are skilled in evaluating individual cases in the light of their professional knowledge and this knowledge is based on scientific research. Here we enter a third level of analysis: professional knowledge and its basis in *scientific knowledge* and the use of scientific resources. For instance, the science of psychopathology is based on a huge group of sciences, pre-clinical and clinical, and historic developments. Resistance as a concept is based on psychodynamic thinking, psychotherapeutic research and developments in the practice of psychotherapy. It is no surprise that something similar can be said about religion. Here I mean religion as object of scientific research. One may think of the ongoing change of the religious landscape in a country such as the Netherlands, in Western Europe, or in any part of the world, or the influence of secularization on the development of psychopathology. Religion is anything but a fixed entity; it never was fixed. People might have the impression that theology is about fixed doctrinal positions, but it never was. Again, this leaves us with a mixture of directions, thoughts, scientific disciplines, approaches, data and so on.

How can one relate all these aspects to each other? This brings us to our next level of analysis, an even higher level of abstraction: the *philosophical level* reflecting on the interrelations between these phenomena, abstractions, theories and constructions. And still it refers to the

experience we started with, the daily, common experience of everything being connected with everything.

One of the core aspects of this fourth level is reflection on the inter-level relationships. And again, this is reflection on inter-level relations within different domains. The relationships between body, mind, soul or self differ from the relationships between scientific disciplines such as genetics, brain science and personality psychology and psychopathology. And these, in turn, differ from the relationships between cognitive science, cognitive science of religion, philosophy of religion and theology. What about the relationships between these domains? And what is the meaning and relevance of these relationships for the patient's question about his or her religious life?

I assume that these levels of observation and understanding will help us to better understand the controversies in a heuristic way. After all, it would be possible that things are thrown together or not distinguished well enough, with confusion as a result. Could this be a partial explanation of the controversies? If that were the case, the solution of the controversies could be a lot easier: paying more attention to the various languages: everyday (colloquial) language, clinical language, scientific language and meta-theoretical or philosophical language. One can imagine what happens when we mix up these languages, or claim that only one or two languages really matter.

Strategies

Given this very complex picture, a few keywords indicate strategies to do something about it, to make it look less complex. For instance, one strategy is reduction. In brief: Higher levels of complexity are composed of simpler, lower level entities, and it is possible, or will be possible in the future, to explain the former by reducing them to the simpler level, to the less complex constituents. Ultimately, reduction will lead to replacement of the more complex theory by the less complex ones. Simply stated: mind is brain, and religion is brain, meaning that mind can be reduced to brain, and equally religion can be reduced to brain functions. It is fair to say that to date these reductions have not yet been accomplished in a satisfactory way. I also do not expect this strategy to be the only one to be helpful for our purpose here.

Is it really the case that in the inter-theoretical relationships reduction and replacement are the desired standard? Another strategy might be more promising. According to De Jong (2002) this reduction-replacement approach is a mixture of theory reduction with theory succession. Of course, one theory can be succeeded by a subsequent one, based on the fact that the new theory is better than the previous one (diachronic dimension; De Jong, 2002). However, it is also possible "that at the same point in time theories make contact", along a continuum from elements ready for reductions to "*coexistence of incompatible theories*" (synchronic dimension; italics added; 2002, p. 449). Put in that way, "theories at different levels of description can co-evolve and mutually influence each other *without the higher level theory being replaced by, or reduced to, the lower-level one*" (psychology of religion, theories of psychopathology and neuroscience; italics added; De Jong, 2002, p. 450). Gervais draws the same conclusion: "Explanations at different levels can exhibit anything from reduction to mutual co-evolution, from elimination to integration." (Gervais, 2014, p. 2; Visala, 2018; see also Drees, 2010, p. 141).

I expect this "continuum view" to be helpful for several reasons. We are not forced to rule out any type or level of explanation, beforehand. Descriptions of phenomena at different levels can co-exist and influence each other. Having multiple inter-level explanations, although complex, can stimulate scientific progress instead of obstructing it (Gervais, 2014, p. 2). The appropriate approach to complexity does not always have to be the dismantling (reduction) of that complexity.

A third, even more pluralistic strategy is available. It sees the other two approaches, the reductionist and the continuum view, as viable options, and adds a third perspective that allows for both integration and isolation. The choice for integration or isolation, as well as the other approaches, depends on scientific purposes, fruitfulness, context and other, more pragmatic concerns. What do we strive for? The reductionist approach is a monist perspective, which is not always possible to achieve, but nevertheless a realistic option. The continuum approach suggests that reductionist strategies do not rule out a co-evolutionary and interactive perspective and that both can be combined, together or in succession. The third, even more pluralistic strategy suggests that there are two other perspectives as well: an integrationist and an isolationist perspective. The integrationist perspective strives to inte-

grate the findings of different theories or programs, which could lead, but perhaps not always, to a better explanation. The isolationist approach accepts that not all explanations can be integrated and that isolation is neither always avoidable, nor necessarily needs to be avoided (Gijsbers, 2016).

With the help of these three approaches to inter-theoretic, inter-level relationships (reduction, diachronic and synchronic, monist, integrationist, and isolationist perspectives) I have created a certain amount of latitude to frame my search for controversies and consensus. Although it seems as if the observation of a multitude of theories and explanations on different levels and within different domains may lead to the image of a chaotic potpourri of conflicting or contradictory theories, it is not much of a problem as long as we are willing to use the proposed strategies.

Outline

The foregoing indicates the framework within which my study takes place. The body of the thesis is divided into two parts, each preceded by a short introduction. Chapter 2, the first chapter of Part I "Controversies", is about the World Psychiatric Association Section on Religion, Spirituality and Psychiatry and its ambitious agenda, especially with regard to a consensus on psychiatry and religion among psychiatrists worldwide. It serves as a description of the goals, certainties and motives of the WPA Section on Religion, Spirituality and Psychiatry. It is about how we started, what we had in mind, what we hoped for, and wanted to achieve with regard to religion or spirituality in psychiatry. A great deal was already known, but how could that knowledge gain a foothold in clinical practice? We formulated an ambitious plan of action.

In three consecutive chapters (Chapter 3-5) I then explore the controversies on psychiatry and religion by extensively reviewing the relevant literature. An overview of essential information is presented and relevant literature is reviewed especially with regard to the attitude of psychiatrists towards religion (and spirituality).

Chapter 3[2] is a review with the aim highlighting that the indifferent, undecided, and rarely positive attitude of psychiatrists towards the relationship between psychiatry and religion (and spirituality) stands in contradiction to extensive data. This evidence reveals a largely positive relationship between religiosity/spirituality and various indices of health. Despite the attitude of psychiatrists in general, the neglect of this fact is difficult to justify. However, religious and spiritual beliefs and practices are powerful forces and may impart harmful as well as beneficial effects.

Whatever disagreements there might be on definition and use, spirituality and religion are concerned with the core beliefs, values and experiences of human beings. A consideration of their relevance should therefore be a central part of clinical and academic psychiatry.

Chapter 4 is a more extensive review concerning the controversial issues of psychiatry and religion and is based on the assumptions from Chapter 3: (a) Religious or spiritual well-being is an important aspect of health; (b) Empirical evidence reveals a largely positive relationship between religiosity/spirituality and various indices of health; (c) Psychiatrists should always be expected to respect and be sensitive to the spiritual/religious beliefs and practices of their patients, and not to use their professional position for proselytizing or undermining faith.

I take a thematic approach based on recent scholarly literature. In the first part I explore the impact of modernization on religion and culture in the Western world. In the second part I evaluate the meaning of empirical research that has been done to investigate the relationship between religion (or spirituality) and mental health. In the third part I discuss the topics of attitude, professional practice and awareness.

The European and World Values Surveys have been very useful in understanding what is happening to religion and the existential-psychocultural context in which Western people live. By means of a representative meta-analysis the mixed findings are shown and the difficulties, pitfalls and possible solutions exposed. Spiritual history-taking is

2 It turned out to be useful to append some additional comments to the published texts. This is done in the notes. These comments emphatically do not belong to the original texts. However, notes 2 and 3 in Chapter 7 and notes 2 and 3 in Chapter 8 are part of the original texts.

used as a topic to illustrate the sometimes heated discussions, in order to find a way to transcend boundaries that interfere with productive dialogue.

The overall conclusion is that psychiatrists should cast off their distrust and acknowledge that it is a matter of professionalism to include religion and spirituality in patient care.

In Chapter 5 the review is resumed and expanded. According to a mixed methods approach I confront the evaluation of empirical results with an ethical discussion on evidence-based psychiatry. On the basis of four reviews from 1969-2013 I show the progress that was made and the achievements that were accomplished. In doing their empirical work the researchers managed to comply with the evidence-based medicine approach. However, we must ask what the consequences of that compliance are. And in what sense religion could become part of "the most effective means of achieving health". The evidence-based medicine approach to the study of religiosity in psychiatric patients calls for a critical ethical evaluation.

I conclude that the evidence-based or empirical approach to religion in psychiatry is far from neutral. In fact it redefined the essence of religion to fit the evidence-based ideal: religion is OK because it is good for your health. As a consequence, compared with religious traditions religion is given a different content with a strong experiential-expressive focus. This focus fits perfectly with modern Western values, as I reported in Chapter 4. Finally, the findings and discussions enable me to present four preliminary scenarios for the impact on psychiatry and mental health of research on religion/spirituality.

In Part II (Consensus) I explore the possibility of a consensus with regard to religion in psychiatry. This is preceded by a short introduction. In Chapter 6 "Towards a position statement", I broaden my call for action to the psychiatric community worldwide. After all, the question is how to go beyond the controversies. Four contributions (6.1, 6.2, 6.3 and 6.4) are combined under this heading. In Sections 6.1 and 6.2 I focus on the science-and-religion debate and I call for scientific quality in our reflections. Section 6.3 consists of my appeal to the leadership of WPA. Section 6.4 concludes the chapter with the text of the WPA consensus document as it was published in February 2016.

In Chapter 7 I describe more extensively the criteria on which the statement is based and I formulate desiderata. The acceptance of the statement and the acceptance of similar statements by other national associations for psychiatry around the world mark a new phase in the hope that research will show that these statements actually have impact on clinical practice.

In Chapter 8 the scope is different. A theological model on spiritual life and relational functioning is introduced. In the first place it is meant to be a contribution to the relational turn in psychology of religion. As a theological model it is a newcomer in this field, although it is not the first time that the model has been explained to the field of psychology and psychiatry with this purpose. The discussion then shifts to a proposal for a dialogue with DSM-5™, especially with the section on an alternative approach to personality disorders. The conclusion is that there is a clear basis for such a dialogue.

Part III offers a conclusion. In a General discussion (Chapter 9) I summarise and critically discuss the main findings of the research, consider its implications and how it advances the field, and I set out desiderata for future work by formulating a "Hilbert problem".

About religion

This thesis is about psychiatry-and-religion. That means that it is not essentially about psychiatry and religion separately. And yet, a final question remains: given my own religious beliefs, how do I relate to, develop myself with respect to that powerful and colourful variety of religions and spiritual traditions? However, this question is multi-layered, in line with my approach. It is not only about relating as a professional to daily religious experiences from various traditions. It is also about having a professional, collegial attitude. In my profession I relate to all those colleagues, wherever in the world, who, like me, intentionally or unintentionally live their religious and spiritual beliefs. It is also about how these experiences and encounters have influenced my own professional attitude, and indeed my own religious views.

I do not believe that all religions, when it comes down to it, are the same or are other expressions of the same, or that there is one central theme that always returns, or that there is a core of everything, such as Karen Armstrong with extraordinary expertise has proposed (Armstrong, 2011), or as the experiential-expressive conception of religion would have us believe. How could a person know that, by the way? It takes a lifetime to own one's religious or spiritual tradition entirely. I tend to agree with Polkinghorne (2011), who explains: "There certainly are such commonalities … but on their own these amount to something that falls short of the spiritual depth and vibrancy to be found in each of the individual traditions" (pp. 133-134). When I suggested that Hindu colleagues, in case of a religious history taking, ask their patients which gods are favourite and which are not, they started to laugh. One does not suggest something like that to a Hindu. This was serious ignorance on my part. "(…) Hindus have defined themselves not by beliefs, (…), but by practices" (Doniger, 2013, p. 8). People do not talk about their gods, they live with their gods in daily devotion and rituals. I believe that there is a certain incommensurability among religions. There are non-translatable words and categories, and terms cannot be exchanged between one religion and another (e.g., Jesus as a guru, the Vedas as the Hindu Bible) (Malhotra, 2013, p. 250). So what remains is deep respect! In fact, that respect requires its own spirituality. In that context, my conviction that judgement is in safer hands with the Supreme than with us enables me to abstain from any judgement.

The consensus document, which ends this thesis provides no definitions of religion and spirituality, although it acknowledges that this is obviously a problem. Nevertheless, I cannot escape from indicating a direction in which I intend to go. In general terms I accept the following description of religion (first a quotation, then my paraphrase): "*Religion* wird hier weder substantialistisch durch Rekurs auf eine wesenhafte "Essenz" oder "Substanz" (Heiliges, Numinoses, Absolutes etc.), noch nur functional definiert (z.B. Reduktion von Kontingenz). (…). (…) unter *hermeneutischer* Perspektive wird Religion hier als eine *irreduzibele kulturelle Form funktionaler Relationen* verstanden (…), die manifest wird in *symbolisierenden und organisierenden Praktiken* (…) mit spezifischer Codierung und Semantik (…), zur *Deutung von Erfahrung*

(…), zum Zweck der *Orientierung* (…) bzw. *Ordnung* (…) in der so gedeuteten Wirklichkeit"[3] (Stoellger, 2014, pp. 4-5).

In this phenomenological description I appreciate the aspect of self-understanding of religion(s) instead of the necessity of having to choose between substantive versus functional approaches, or combinations of these two approaches (Oman, 2013). Religion is a response to lived experiences "involved in understanding your life in one way or another" (Taylor, 2007, p. 5). In these experiences we *relate* to aspects of life we cannot or will not accept or to aspects of life we do not understand or we cannot control. The former response can be critical, a protest (prophetic), the latter positive or grateful (mystical; Drees, 1996). In both senses the response is related to a view of life and draws on all sorts of resources and practices in a coherent way (Brümmer, 2006; Drees, 1996; Feil, 2000; Markus, 2004; Mühling, 2014). Experiencing these aspects in certain activities or conditions or at certain times may be positive or negative. However, the words positive and negative are inappropriate (i.e., too formal): they are not sufficiently typical within the realm of religion and view of life. Uplifting or frightening do more justice to the intended nature of the experience (Taylor, 2007). However, as Taylor (2007) beautifully explains: "There may be just moments when the deep divisions, distractions, worries, sadnesses that seem to drag us down are somehow dissolved, or brought into alignment, so that we feel united, moving forward, suddenly capable and full of energy. Our highest aspirations and our life energies are somehow lined up, reinforcing each other, instead of producing psychic gridlock" (p. 6). That is how these experiences help us to orient ourselves when we had lost our way and became dizzy, and help us to find order when we had forgotten and were troubled in the thus interpreted reality.

3 Religion is here neither substantively defined by recourse to a substantial "essence" or "substance" (sacred, numinous, absolute, etc.), nor merely functional (for example, contingency reduction). (…) From a *hermeneutical* perspective, religion is understood here as an *irreducible cultural form of functional relationships* (…), which becomes manifest in *symbolizing and organizing practices* (…) with specific coding and semantics (…), for the interpretation of experience (…), for the purpose of *orienting* (…) respectively *ordering* (…) oneself in the thus interpreted reality.

However, we should be realistic. "The empirical study of religion rarely addresses this central characteristic of religion itself" (Braam, 1999, p. 7). So what I find is that in empirical studies multidimensional constructs and dimensions of religiousness are used and measures for religion are chosen to obtain a range of variables for religiousness. It is what it is, if only we realize that the (fundamental) distinction between substantive and functional traditions is a tool and that the combination, however difficult, is preferred (Utsch, 1998).

About psychiatry

I intend to be brief about psychiatry. It is a medical specialty dedicated to the prevention, diagnosis, treatment and recovery from mental disorders (i.e. bio-psychosocial-spiritual complexities) in accordance with national and international standards and practice guidelines. And it is also a clinical practice. However, this short description undoubtedly lacks the complexity of psychiatry, also in relation to religion. This complexity results in part from tensions between underlying, more fundamental assumptions. From its origin psychiatry has existed in a tense relationship with church and religion. Nevertheless, psychiatry was in fact the first successful alternative discourse in parallel to the religious approach to insanity (Vandermeersch & Westerink, 2007) and has occupied a unique position within the field of medicine. Another source of complexity is the ongoing discussion about psychiatry itself, as a scientific and clinical discipline within the realm of medicine. Some describe it as an "amalgam discipline located on the border between science and humanities" in which "divergent disciplinary languages" are used (Stoyanov, Borgwardt, & Varga, 2015, p. 129, p. 133). This conceptual complexity is typical of psychiatry and causes problems and challenges that directly affect our project. Cloninger (2015) summarized this conceptual complexity in this way: "The fundamental challenge is that common mental disorders are complex phenomena that result from non-linear interactions among multiple biological, mental, social, and spiritual processes that influence the development" (p. 205).

In other words, religion as a phenomenon takes place as an everyday life experience. Psychiatry is an ambiguous enterprise that refers

to clinical and scientific practice. And at the same time religion has its own "clinical" practice (e.g., all kinds of "pastoral" care), and science (e.g., all kinds of practical theology).

Exhortation

What does it mean to be human in our days and age? There is an enormous diversity in sources that provide guidance regarding the purpose of life. How do we fulfill our purpose, how do we deal with our desires and frustrations, where do we search for happiness and flourishing? We continuously must reinvent ourselves (Verhagen, 2016). Alongside theologians and philosophers, psychologists, artists, poets, writers, photographers and musicians help us in this task of reinventing ourselves. Does the psychiatrist belong to this corps of "reinventors"? The initial answer is probably negative. For medical professionals, the reinvention of our state of being is far beyond their scope. On the other hand, the answer can be cautiously affirmative. Why? Because as medical professional the psychiatrist has to deal with the complexities the patient is facing in his and her struggle with mental disease in daily lived experience. And that, with all its difficulties, can be seen as a special form of reinventing more than restoring or improving, even though restoring and improving are indispensable.

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Part I. Controversies

The first chapter of this Part I – Chapter 2 – reports on the mission of the WPA Section on Religion, Spirituality and Psychiatry which was newly established in 2003. It signalled what followed in the years to come. In three subsequent papers the controversies are outlined and commented on. Chapter 3 introduces the matter of the attitude as "an old song over again". The controversies are presented under three headings in Chapter 4: the meaning of religion in a world of changing values maps, the meaning of empirical research on religion and psychiatry, and the attitude of the mental health professional, especially the psychiatrist. The last chapter of Part I – Chapter 5 – evaluates the improvements of empirical research on religion in psychiatry in a positive way, but advances a critical evaluation of its underlying values, which have consequences for the interpretation of religion in relation to mental health.

The indication "controversies" when it comes to psychiatry and religion is not new. Bughra edited a book with a quite similar title as this thesis: *Psychiatry and Religion. Context, Consensus and Controversies* (1996).[1] The book title is not the most important reason to mention his name. Denish Bhugra was president of the Royal College of Psychiatrists (London) at the time the Royal College of Psychiatrists Position Statement on spirituality and religion in psychiatry was accepted (2011). And again, he was president of the WPA at the time the WPA Position Statement was approved and published (2016). That is no coincidence and I know personally how valuable his leadership has been in the whole process after a short period of stagnation.

1 Bhugra, D. (Ed.) (1996). *Psychiatry and Religion: Context, Consensus and Controversies*. London: Routledge.

I quote a few characteristic lines from his introductory chapter: "Whereas formerly, the mentally ill were seen by the priests as possessed by spirits, demons, and devils, their odd behaviour was subsequently explained away by psychiatry as "illness of the mind". … The competition between the priest and the psychiatrist for the mind and the soul of the individual continued. … Science without religion can be destructive, and religion without science can become superstition (…)." (Bhugra, 1996, p. 2).

These sentences give a striking characterization of the background of the controversy: a competition between two discourses (and their representatives), that, as a matter of principle, cannot do without each other.

Chapter 2

Religion, spirituality and psychiatry A field wide open for discussion and research[1]

A look back at the beginnings of a new WPA Section

From the very moment that the World Psychiatric Association (WPA) Section on Religion, Spirituality and Psychiatry was founded (2003) it was clear that the Section had to prove its value among the other sections within the WPA organization. It also had to present an appealing program, which was requested as part of the application to obtain

1 Chapter 2 is based on three publications:
   a) Van Praag, H.M., & Verhagen P.J. (2005). Religion, spirituality and psychiatry: A field wide open for discussion and research. In G.N. Christodoulou (Ed.), *Advances in Psychiatry. Second Volume* (pp. 251-258). Athens: World Psychiatric Association.
   b) Verhagen, P.J., & Van Praag, H.M. (2006). Religie, spiritualiteit en psychiatrie: Een breed terrein voor discussie en onderzoek [Religion, spirituality and psychiatry: A field wide open for discussion and research]. In T.I. Oei, & M.S. Groenhuijsen (Eds.), *Capita selecta van de forensische psychiatrie anno 2006* [Capita selecta of forensic psychiatry anno 2006] (pp. 57-76). Deventer: Kluwer.
   c) Cox, J.L., & Verhagen, P.J. (2011). Spirituality, religion and psychopathology: Towards an integrative psychiatry [Special issue]. *International Journal of Person Centered Medicine, 1*(1), 146-148.

   Publication (a) served as a discussion paper on behalf of the WPA Section on Religion, Spirituality and Psychiatry. It was circulated among colleagues around the world and sent to the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists (Verhagen & Cook, 2011, p. 615). Publication (b) is an extended version of publication (a).

approval by the WPA General Assembly. In the late 1990s a first attempt to found a section on religion and spirituality had failed due to lack of support. Herman van Praag, well-known emeritus professor of psychiatry (the Netherlands), took the initiative and became the founding chair. Driss Moussaoui, professor of psychiatry in Casablanca (Morocco) accepted the position of co-chair and Peter J. Verhagen, psychiatrist and theologian (the Netherlands), became the founding secretary.[2] Was it not to be expected that a section on religion and spirituality would be an odd man out?

To answer that question, I will describe the context within which the sections of WPA operate.

The function and purposes of WPA and of its sections are laid down in its statutes and bylaws (WPA, 2017). The general purposes of the WPA as spelled out on its website are to:

1. Increase knowledge and skills necessary for work in the field of mental health and in the care for people with mental disorders/mental illness, substance use disorders and related disability;
2. Promote the application of public health principles in the fields of psychiatry and mental health;
3. Support action to prevent mental disorders;
4. Support action to promote mental health;
5. Support action to diagnose and manage comorbidity between physical and mental illnesses/mental disorders;
6. Advocate and apply ethical principles and the observance of human rights of people with mental illnesses/mental disorders and their carers and families in care, research and teaching;
7. Ensure equity as well as parity (non-discrimination) in the access to and the quality of care and in other areas of life of people with mental illnesses/mental disorders;
8. Promote the development and observance of the highest quality standards in psychiatric care, teaching and research;
9. Protect the professional rights of psychiatrists.

2 The other members of the Section committee at that time were: H.G. Koenig (USA), A. Mohit (IR), R.S. Murthy (IN), A. Okasha (EG).

The challenge for the sections is to meet the WPA goals with respect to their specific area of interest. This is why the sections are called the backbone of WPA: they perform the necessary substantive activities in accordance with its goals. The purpose of WPA scientific sections is formulated as follows:

a) The collection, analysis, presentation and dissemination of information concerning services, research and training in the various fields of psychiatry and mental health and the advancement of scientific knowledge in these fields.
b) WPA scientific sections will achieve this purpose by the:
    1. Organization of scientific meetings on topics of interest to WPA Scientific Section;
    2. Organization of Symposia dealing with a given Scientific Section's specialty, at WPA Congresses and co-sponsored meetings;
    3. Development of educational programs, guidelines and related scientific publications;
    4. Development of proposals for adoption as WPA consensus and position statements;
    5. Promotion and conduct and facilitation of international collaborative research activities;
    6. Developing programs in consultation with other Scientific Sections and promoting intersectional activities;
    7. Preparation of regular financial reports as requested by the Executive Committee.

The WPA bylaws also specify the grounds on which a section can be established:

a) To obtain ad hoc approval, the new WPA Scientific Section must:
    1. Submit the necessary terms of reference to the WPA Secretary for Sections to define the area of specialty of the proposed Section, and indicate how the proposed Section differs from other Sections dealing with related matters;
    2. Have an organizing committee consisting of at least ten members, no more than two of which may be from the same country;
    3. Present a plan for what activities it proposes to undertake.

b) The WPA General Assembly immediately following the ad hoc establishment of the Section, will give permanent approval to the WPA Section provided that it has:
   1. A roster of 20 or more members that has been accepted by the WPA Secretary for Sections;
   2. Elected a WPA Section Committee from among its members consisting of no more than eight members, three of whom shall be a Chair, a Co-chair and a Secretary of the WPA Section. The Section Committee shall be the governing body of the Section;
   3. Has produced a program of its planned activities and indicated its relevance to the achievement of WPA goals.

Based on brief working documents and discussions during symposia organized by the Section,[3] the Section board was able to present a plan in accordance with the aforementioned rules and obligations. We were not only convinced that religion and spirituality play a role in psychiatry, but also that recognition of the importance of the theme was perfectly compatible with the general aims of WPA. We formulated the mission of the WPA Section on religion, spirituality and psychiatry as follows:

Mission and goals

Mission

The WPA Section on Religion, Spirituality and Psychiatry has a clear mission:

3 The first symposium was held by the Section-in-formation during the International WPA congress in Madrid in 2001: *Psychiatry and religion: clinical training and research*. Contributors: Herman van Praag (moderator; NL), Gerrit Glas (NL), Peter J. Verhagen (NL), Arjan Braam (NL), Andrew Sims (UK). The first symposium as a Section was held during the WPA international thematic conference in Vienna in 2003: *The importance of religious variables in psychiatric diagnosis*. Contributors: Herman van Praag (NL), Driss Moussaoui (MA), Peter J. Verhagen (NL), Michael King (UK).

- To focus attention on religiosity and spirituality as major experiential domains in many individuals.
- To communicate to psychiatrists that the search for meaning in one's life, the need for a transcendental dimension, the urge to reach out to a world beyond the horizon, is a key feature of the human condition.
- To underline that neglect of this terrain in psychiatry implies missing out on diagnostic comprehensiveness and therapeutic opportunities.

Goals

The goals we want to promote are the following:

- Introduction of religious history taking as a routine. In the analysis of personality characteristics religiosity/spirituality should have its legitimate place.
- Residency training and continuing professional development.
- Professional standards require psychiatrists to maintain, develop and remedy any deficits (including religion and spirituality) in the knowledge, skills and attitude relevant to their professional work.
- Research into the therapeutic significance of religious variables.
- Analyses of the complex construct religiosity/spirituality.
- Development/improvement of assessment methods.
- The utility of existing methods must be studied and where necessary new measuring instruments developed.
- Promotion of effect studies.

Obviously, the role of religiosity/spirituality in psychiatry is wide open for discussion and research. Our Section hopes to promote just that.

In addition to this formulation of the mission and goals, we explored the state of the field at that time to provide an overview of possibilities, instead of reiterating the old controversies. However, we acknowledged that these controversies were still present within the possibilities we looked for and tried to put forward. Over the past 100 years or so the terrain of religion and spirituality in psychiatry had fallen into neglect. Even worse, psychiatrists tended to qualify religiosity as a neurotic, infantile relic of the past; if anything, religiosity was something to be treated, not to be cherished. Therefore, our first main point of

interest was to survey the views of psychiatric associations around the world on the topic of religion and spirituality in psychiatry. Were there any formal (or informal) statements on the topic? Secondly, we looked for common ground or interfaces between psychiatry, religion and spirituality. What could be stated, in very general terms, on mental health and religious psychopathology? We addressed two other topics as well: psychotherapy and religion and spirituality, and residency training and continuous medical education. In our view these four items formed almost the entire field of psychiatric practice. That is not by coincidence, but on purpose. It is the claim we put forward. Religion and spirituality is not just a growing exception or oddity but belong to the core of psychiatry, i.e., to the entire field including research and training, from conceptual analysis to daily therapeutic interventions.

Professional associations: Important statements

At that time (2003), formal or informal documents on psychiatry, religion and spirituality were available from psychiatric associations. Several important statements underscored the professional focus on religion and spirituality. According to the Practice Guidelines for the Psychiatric Evaluation of Adults of the American Psychiatric Association (APA), as part of the evaluation of psychiatric patients, important cultural and religious influences on their lives should be collected (APA, 1990, p. 542).

The American College for Graduate Medical Education, referring to residency training in psychiatry, stated in 1994 that all training programs should provide residents with theoretical and empirical knowledge relevant to the role of cultural, religious and spiritual diversity (Grabovac & Ganesan, 2003; Koenig, 1998, p. 324).

In 1992, the College Trainees Committee of the Royal College of Psychiatrists in the UK had recognized the same imperative to "emphasize the physical, mental and spiritual aspects of healing in the training of doctors in general and psychiatrists in particular. Religious and spiritual factors influence the experience and presentation of illness" (Sims, 1994).

Two major changes occurred with the publication of DSM-IV in 1994. The first one was the change in diagnostic nomenclature from

DSM-III-R to DSM-IV with the introduction of religious and/or spiritual problem as a diagnostic code for "additional conditions that may be a focus of clinical attention" (V62.89; APA, 1994, p. 685). The second notable change was the introduction of the cultural formulation meant to supplement the multiaxial diagnostic assessment (APA, 1994, p. 843). In 1999, the president of the World Psychiatric Association, Ahmed Okasha (Egypt), declared that religion has remained an important factor in most patients' lives, no matter where in the world they live. In 1995 the World Health Organization introduced the WPO Quality of Life Assessment in which six domains of quality of life were stipulated: the physical and psychological domains, level of independence, social relationships, environment and spiritual, religious and personal beliefs.

Consequently, at the time the Section was founded, substantial formal material from various sources was available on which we could build and which we could bring to the attention of the psychiatric field. We believed it was essential to do so because these documents and statements had little impact. Paper is patient!

Religion and psychiatry: What attitude?

The attitude of psychiatrists towards religion has always been complicated. In the past, that attitude was labelled as neglectful (Neeleman & Persaud, 1995), sceptical and even overtly hostile (Sims, 1994). Neeleman and Persaud (1995) formulated several reasons for this attitude. The neglect is partly related to psychiatry's progress in elucidating the biological and psychosocial causes of mental illness, rendering religious explanations superfluous. In addition, until recently it was often assumed that religious attitudes were linked with phenomena such as dependence and guilt, which were, and still are, seen as undesirable. Furthermore, psychiatrists and psychologists tend to be less religiously orientated than their patients, which may further increase the professional's idea that religious or spiritual beliefs are associated with disturbance. However, it has long been presumed that religion and mental health may have a positive relationship. The psychology of religion has provided empirical support for that idea. However, psychiatry still had not included this evidence in its theory and practice. In another

survey, Neeleman and King (1993) studied the religious attitudes of 231 psychiatrists in London (UK) in relation to their clinical practice: 27% reported a religious affiliation, 23% a belief in God, and 92% felt that psychiatrists should concern themselves with the religious concerns of their patients. However, there was no evidence that psychiatrists' private religious beliefs had an important influence on their clinical practice. Although more than half of the respondents reported regularly assessing the religious beliefs of their patients, interventions in this area, such as referral to and liaison with the clergy, were relatively rare. In their conclusion the authors noted that psychiatrists were undecided about the role of religious or spiritual belief in the development of, or recovery from, mental illness.

Larson and colleagues explored another example of this complicated or even sceptical attitude of psychiatrists towards religion in 1993. They reviewed appendix C of DSM-III-R published in 1987, which is the glossary of technical terms (APA, 1987). And what they found was very interesting and illustrative regarding insensitivity about religion and spirituality. In their study they reviewed all definitions in the glossary to determine the frequency in which religion was presented as a clinically relevant factor. Secondly, all definitions were further reviewed to determine how sensitively religious examples were used to illustrate psychopathology in the short, illustrative examples of the term. They evaluated how frequently (a) religion was presented as a clinically relevant issue, (b) other cultural issues were presented as clinically relevant issues, (c) religion was used to illustrate psychopathology, and (d) other cultural issues were used to illustrate psychopathology. They found 21 examples of clinically relevant issues, of which 6 had a religious content. Of the remaining 15 issues, only one was related to ethnicity and only one was related to sexuality. They found 45 illustrative case examples of psychopathology: 10 of these cases had religious content, such as "catatonic posturing: a patient may stand with arms outstretched as if he were Jesus on the cross" (APA, 1987, p. 392). In contrast, only two cases had sexual content. Although none of the case examples would seem to be clinically implausible, the context in which they were given (the definitions section of a major document of psychiatric nosology) casts religious commitment in a negative and pathological light, which is rather insensitive to religion and spirituality. Indeed,

as the authors noted, the overutilization of religion as case example of psychopathology supported the simplistic traditional mental health notion that religious commitment fosters psychopathology and that religion is not associated with mental well-being. Obviously these findings and comments were taken seriously. Negative inferences about religion were removed from the glossary in DSM-IV, and the new V code "Religious or Spiritual Problems" was added, as mentioned previously.

This viewpoint, ranging from a-religious to anti-religious, did not benefit psychiatry. Practitioners of this profession have to deal with the subject and come to terms with it. Atheism is not as pervasive as has been suggested. Religion and spirituality did not disappear, and the common man has not abjured religion. Psychiatrists, thus, are not done with religion by declaring that it is out of date, as if it is only a remnant of an archaic stage of human development.

Spirituality and religion

An important complicating element is the lack of agreement on the meaning of terms as they are used in our particular field of inquiry. This has proven to be an important point of attention, because often there is a lack of clarity in discussions, and in empirical research it was not always clear what exactly had been investigated. The construct of spirituality is poorly delineated and hard to define. It refers to a need for, and fascination with, the metaphysical, the transcendent, the mystical, the mysterious and the occult, to a longing for the lofty, the august, the spiritual: that which exceeds the material aspect of human life. However, it still is the question if such a description covers all the manifestations of spirituality (Berghuijs, Pieper, & Bakker, 2013).

Religion, however, is much more structured. Therefore is seems more easy to give a definition of religion. That is too simple in a sense. I previously gave a phenomenological description of religion (pp. 13-14). Here I want to add the distinctions the theologian Küng (2002) made. The Judeo-Christian traditions together with Islam as the Semite, prophetic or Abrahamic religions have no exclusive rights on the term religion. There are also the mystic religions that emerged out of India and the wisdom religions that emerged out of China. Not a prophet, not a

mystic, but a wise man is the central figure. A fourth stream of religions are the tribal or indigenous religions out of Australia and Africa. The editors of the WPA volume Psychiatry and Religion: Beyond Boundaries attached great importance to recognition of these different streams of religions, because they wanted to guard against the suggestion of an all too biased Judeo-Christian position (Verhagen, Van Praag, López-Ibor, Cox, & Moussaoui, 2010, p. XVI; see also Verhagen & Cox, 2010, pp. 596-598).

However, domains of spirituality and of religious practice overlap; most religious traditions encourage adherents to undertake private spiritual exercises. Therefore, an important aspect is the meaning religion has in a person's life. A fruitful approach of this aspect the distinction between intrinsic and extrinsic religiosity. Intrinsic religiosity is personal, subjective religiosity and extrinsic religiosity is more external, more aimed at compliance with rules and regulations, creeds. Intrinsic religiosity is a more personal spirituality derived from, and structured by, religious tradition, whereas spirituality has essentially the characteristics of a private quest for answers to ultimate existential questions about life and death, meaning and purpose, and can include experiences of the transcendent (Batson & Ventis, 1982, pp. 140-144). Intrinsic religiosity means that one lives his and her religion (Abu-Raiya & Pargament, 2012, p. 334).

Today, the landscape has changed dramatically, at least in the Western world. The decline of religion continued, and in recent decades the landscape of spirituality evolved more and more. Interesting research has been done on the semantics of spirituality and religion and on conceptions of spirituality (Berghuijs et al., 2013; Streib, 2014).

Interfaces of psychiatry and religion

Psychiatry and religion are connected on several levels and in various ways. Some of those interfaces are discussed below.

Religion and mental health: Three models

How do religion and mental health relate? Is an adequate explanatory model available? At least three models prevail: the biopsychosocial

model, the stress-vulnerability model and the person-centered medicine approach.

Although the bio-psychosocial model of George Engel (1913-1999) was based on general systems theory, it successfully encouraged doctors to consider the social and psychological aspects of patient care in addition to biological parameters (Engel, 1977, 1980). The model, however, was considered primarily as a causal scientific framework, which disregarded its full potential to promote humanistic, person-centred medicine. Therefore, a biosocial/psycho-spiritual relationship-based approach to health care provision is perhaps closer to the essence of a psychiatry of the person; it is within this wider perspective that consideration of religious faith and spiritual practice optimally resides.

That is why the following question is legitimate and challenging: "Are we ready for a true Biopsychosocial-Spiritual model?" (Saad, De Medeiros, & Mosini, 2017). The authors make a strong plea by referring to the "Physician's Pledge" on the Declaration of Geneva. The pledge is a declaration of dedication of the physician. A phrase from the pledge is the following: "The health and well-being of my patient will be my first consideration". The authors propose a translation of this phrase to the spiritual dimension: "I will value the spiritual values, beliefs and practices of my patient in the clinical encounter, with respect their impact on his/her health". In other words, a biopsychosocial and spiritual approach not only concerns the patient as a person but also the attitude of the professional as a person to the patient as a person (Saad et al., 2017, p. 79).

The stress-vulnerability model is based on the assumption that stressors, in combination with vulnerability, provoke mental illness. Stressors are provoking agents, and vulnerability reflects poor personal resources and attachment styles. However, protecting factors, i.e. stress-buffering effects, might also be at work. Religion and spirituality can act as provoking and/or buffering factors, and as resources. With his approach to religion in empirical perspective, Braam is one advocate of this model. He has demonstrated its usefulness, also from an educational and training perspective (Braam, 2009).

The third model, if it is indeed a model, is relatively new. "The concepts of person-centered medicine and psychiatry for the person offer, perhaps more than any other current biopsychosocial concept, the

opportunity to develop a truly integrated approach to the psychiatric patient as a person suffering from mental turmoil. Within this approach to patients as people, it is often necessary to give thorough attention to the patient's spirituality, religious beliefs or worldview. Person-centered psychiatry offers a well-grounded reason for incorporating spirituality and religion into psychiatric assessment, diagnosis, case-formulation and therapy, and as a component of psychiatric training and continuous professional development" (Cox & Verhagen, 2011, p. 146).

Positive and negative correlations

At the time the Section was founded, for example, it was already known that several studies indicated that religiosity could provide a degree of protection against depression and may enhance remission, in particular in elderly people with few social contacts and little self-confidence (Braam, Beekman, Deeg, Smit, & Van Tilburg, 1997; Braam et al., 2004; Koenig, 1997; Koenig, King, & Benner Carson, 2012; Koenig, McCullough, & Larson, 2001). Religiosity was measured on two levels: (a) extrinsically, registering frequency of church visits and regularity of praying, and (b) intrinsically, trying to gauge the genuineness of religious feelings and the import they have in someone's life, relative to other concerns, such as earning a good income, building a satisfactory family life, enjoying good health, and having succeeded in a career. It appeared to be the plenitude of inner religious life rather than the more formal aspects of religiosity that correlated with the risk of depression and its prognosis.

These results concerning depression seemed encouraging, but investigators had much work to done: they must define the concept of stress in greater detail; establish those elements of intrinsic religiosity with protective potential; develop better instruments to assess religiosity; determine those subtypes of depression that could be influenced specifically by religiosity, and study mental disorders other than depression as to their responsiveness to religious contemplation. Work has been done on some of these questions, but not on all of them.

There is another side to this positive outcome, which has also been known for some time. It seemed also conceivable that religiosity might influence mental health in the reverse direction: undermining rather than boosting mental health. Religion may act as a strait jacket, thwart-

ing spiritual growth, inducing fear and emotionally empty preoccupation with religious precepts. Instead of lightening and illuminating life, religion then becomes a burden, a source of worry. Religious beliefs may shrink to remorseful waiting until death arrives (see also Abu Raiya, Pargament, & Magyar-Russell, 2010, pp. 391-405).

Religious psychopathology

There is no generally accepted classification for religious psychopathology. In fact, the approach of German psychiatrist Kurt Schneider (1928) remained the most common. Based on his own classification of psychiatric disorders Schneider treated the manifestations of religious themes in the disease in question. The group of schizophrenias occupied the largest place. He did not want to offer more than a description of religious experience in abnormal mood states. His preface began with a warning: One would completely misunderstand his book if one wanted to conclude that the author intended to reduce religion to psychological and psychopathological phenomena in order to interpret religion in that way.

Psychopathological phenomena with a religious charge are by no means rare, though less frequent than they were before the cultural revolutions of the 1960s and 1970s, during which the process of secularization was catalysed so strongly, at least in the Western world. Delusions may have a religious content (e.g., the delusion of being Jesus, a biblical prophet, or having a divinely commissioned mission in life) and so may hallucinations (e.g., hearing voices of divine creatures such as angels, or seeing scenes from hell) and obsessive-compulsive symptoms (e.g., the urge to swear, followed by the inner coercion to execute penitential rituals). Cognitions, perceptions and corresponding emotions of this kind raise several fundamental questions.

First of all there is the border issue. In several publications Van Praag (2003, 2010) asked: Where does normality end and pathology begin? What can still be considered as sound religious experiences and considerations, and what are clearly morbid elaborations? A more phenomenological approach can highlight important difference between, for instance, the self-experience of religious or spiritual experiences from that of psychopathological experiences and symptoms (Jackson & Fulford, 1997; Sims, 1994). If one wants to adhere to the term psychotic one has to acknowledge that psychosis evidently can produce

insights of great philosophical, ethical and artistic value. "Sims (2003) has written succinctly about the need for religious knowledge when eliciting patients' psychopathology, establishing a differential diagnosis, and making comprehensive management plans. The religious colouring of mental symptoms such as hearing God's voice, visions of angels, (…) near-death experiences and mystical states demand a mastery of clinical assessment skills as well as cultural competence." (Cox & Verhagen, 2011, p. 147-148).

In this context, another question looms. Can thoughts and experiences, which by themselves are pathological, be coherent and directional to such a degree that groups of people come to believe in them? The answer is probably in the affirmative. Psychopathological symptoms are not necessarily regressive in the sense that they injure or diminish the richness of a personality. They may be enriching, adding dimensions to a personality that were not detectable before. In psychiatry one may encounter creative maladies (Van Praag, 2003).

This raises a series of questions. Where can we draw a line between fancy and frenzy, between creative novelty and grotesque chimeras? Another fundamental question is whether the religious themes have played a role in the causation of the disorder. Are they a consequence of the disorder, just colouring its presentation, or have they contributed to its occurrence? A related question is whether the religious reflections are culture-bound or nature-bound. Is religious psychopathology restricted to patients raised and steeped in a religious milieu or do they also occur in those averse to religion or ignorant of the religion that produced the ideas being more or less characterologically deformed by the patient? Phrased on a more fundamental level: can illnesses of the mind give rise to novelty, or is morbid content always derived from memory traces stored in the archives of the brain? Is it possible that under certain conditions themes can be generated that do not rest on previous experiences, for which there is no original in the experiential and cognitive files of that individual?

These questions are currently unanswerable but, fortunately, interest to study them appears to be growing. Nevertheless, psychiatry today wants to be strictly evidence-based, and the only data considered to be evidence are those derived from controlled studies of groups of patients that are as large as possible. Besides the evidence-based

approach the questions raised above also require detailed case studies, which lead to individualized (personalized) probability statements and not to more definitive, generalizable conclusions (see also Chapter 5). There is another aspect. The issues raised are theoretically interesting because they enhance insights into the relationships between the phenomenology of mental disorder and the social/religious milieu in which the patient was raised and his or her life history. Psychiatry could be enriched with that kind of insights.

Psychotherapy

Religious and spiritual issues have a role to play in psychotherapy. The reasoning to support this statement is as follows. Mental disorders are the product of two complex processes. First of all, a set of dysfunctions in brain systems is involved in behavioural regulation. These dysfunctions lie at the root of disturbances, in particular in the psychic domains of cognition, perception, emotional regulation and many others. The brain dysfunctions underlying abnormal behaviour and experiences are in turn caused by a variety of agents, biological and psychological in nature.

Psychological factors can also exert a major influence on brain development and brain functioning. Severe psychological traumatization, whether acute or chronic, has measurable and often lasting effects on the brain. For example, strong evidence suggests that adversity during early development may increase the sensitivity for stress and lead to an increased risk for depression and maladaptive behaviour (Bremner & Vermetten, 2001; Van Praag, De Kloet, & Van Os, 2004). Conversely, stress-reduction and strengthening coping-skills may reduce the risk of mental breakdown in trying days, or limit their impact.

Religion and spirituality are part of human psychological functioning. It seems plausible to assume that, if experienced positively, religion and spirituality could promote mental repose and stability, while exerting opposite effects if religious notions are experienced as repressive and frightening.

Why should we address religion and spirituality in psychotherapy? There are several reasons to do so, which I have summarized briefly here. First, addressing these issues will help the therapist better understand the patient's problem, conflicts, symptoms and signs. Second, knowing more about the patient's religious and spiritual background

can be of great help in designing interventions that are more sensitive to the patient and his or her faith and worldview. Third, religion and spirituality can be relied on as healthy resources. Interventions in this realm include listening to and validating healthy forms of religious and spiritual coping. Fourth, negative religious and spiritual experiences may interfere with coping and utilising these healthy resources. Interventions in this realm involve challenging maladaptive religious and spiritual cognitions and behaviours and using the patient's worldview to alter these cognitions and behaviours. Finally, addressing religious and spiritual issues may strengthen the working alliance between patient and therapist.

Residency training and continuing professional development

Mental health professionals increasingly acknowledge the need for competency regarding religion and spirituality issues in psychiatry. An adequate and fruitful approach to the understanding of spirituality and psychopathology requires a multidisciplinary paradigm. Psychiatrists should therefore be exposed to training on the relevance of religion and spirituality to the causes, diagnosis and management of mental disorders from a variety of teaching disciplines, as well as to wider philosophical assumptions underlying mental health.

Such training could be a component of an ethics or transcultural psychiatry course, which should facilitate awareness of the practitioner's own values and beliefs. Sensitivity to these issues is facilitated by mentors, role models, and through the careful supervision of clinical experience. Postgraduate students with special interest in comparative religion or training in theology can make a specific contribution to this growing research and clinical field. The teaching of descriptive psychopathology should include the relevance of beliefs and spiritual practices as they impact on the causes, diagnosis and treatments of mental disorders. Trainees can be alerted to the available research methods in this field, which include well validated questionnaires, such as the one by King, Speck, and Thomas (2001) and several major literature reviews.

Religious assessment

An important topic for training concerns a religious or spiritual assessment. Important cultural, religious and spiritual influences on the psychiatric patient's life should be collected as part of his or her evaluation. A clear understanding of the religious background of the patient gives the clinician an idea of the world the patient inhabits and thus increases the clinician's capacity to empathically understand and work sensitively with the patient. It answers questions such as the following: How does the patient interpret what is going on from a larger perspective? In what way do current problems harm or threaten the values that are most cherished, the ultimate aspect of the patient's life? What are his or her sorrows and preoccupations? But this training also answers questions from the opposite perspective: What is the impact of religion on the present problems and current psychopathology? Is the patient's religious orientation healthy or unhealthy? Taking a religious or spiritual history can help the clinician determine whether the patient's beliefs and community could be used as a resource to foster them better coping, healing, and growth. What are these sources, both spiritual and practical, that can be drawn upon in the course of treatment? Does it give clues for the use of religious or spiritual interventions? Or does it mean that the clinician should look for collaboration with a mental health professional trained in religious or spiritual issues, or with skilled clergy?

In other words, what skills are needed? The resident and the psychiatrist should demonstrate competence in exploring the patient's beliefs in God or a supernatural being and listening for the role religious/spiritual beliefs play in a patient's life. The psychiatrist should demonstrate competence in inquiring about a patient's use of religious and spiritual practices and the impact of these practices upon patient behaviours, conflicts and views about mental health. The psychiatrist should demonstrate competence in interviewing with sensitivity to communication styles, religious language and nuances of religious/spiritual/cultural meaning. And the psychiatrist should demonstrate competence in eliciting, interpreting and discussing religious patients' religious issues and concerns in a non-judgemental manner (Verhagen & Cox, 2010, pp. 599-603).

Putting things together

Cox and Verhagen (2011) assessed the results of their brief review as follows. Religiosity and spirituality are multidimensional constructs related to biological, affective, cognitive, relational, personality, social and cultural aspects of the clinical encounter. Furthermore, they can each be associated with good mental health, through providing support and explanation for adverse events, but can still cause emotional distress and trigger mental disorder.

There is a pressing need for more evaluative studies of the biosocial psychospiritual approach to a psychiatry of the person and for developing operational definitions of its components. User surveys, the careful documentation of clinical practice (including adverse outcomes) and controlled treatment studies are all necessary to show whether this approach is cost effective as well as humane and ethical.

Research summarized by Koenig and colleagues (Koenig et al., 2012, 2001), however, has found that moderate religiosity generally has a positive association with psychological adjustment. The pathways to explain these associations are considered with reference to factors common to both, and factors which mediate, i.e., make links, between religion and health. Factors in common include genetic, biological, developmental, personality and social factors. Mediating factors include social support, hope, confession and prohibitions on diet and alcohol (Figure 1).

This figure is very basic indeed. Koenig et al. (2012) presented a more sophisticated model that was differentiated between Western monotheistic religions, Eastern mono/polytheistic, pantheistic and non-theistic religions, and secular humanism (pp. 308-309). The main difference is the ultimate source of their view of life.

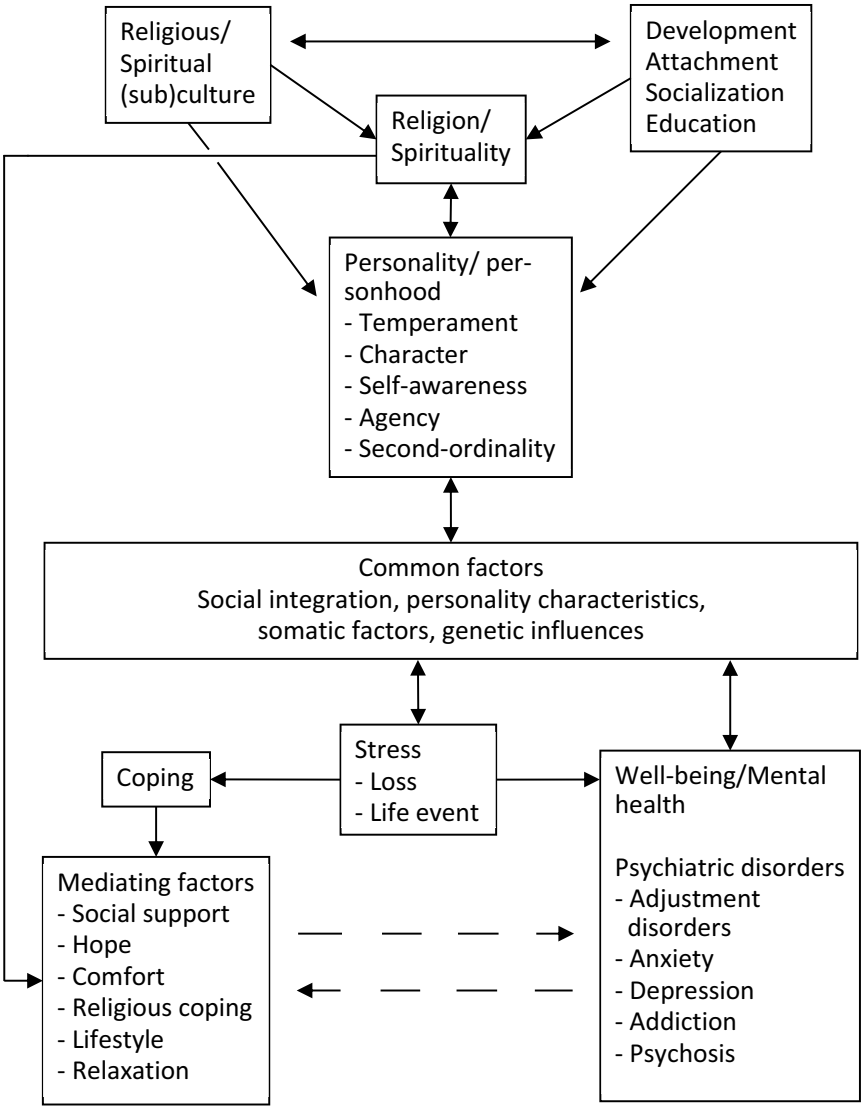

Figure 1. Theoretical model of the interface between religion, spirituality, mental health and psychiatric disorders

Conclusion

In the above we have shown that religion is not irrelevant to psychiatry. On various levels these two domains interface and overlap. Yet over the past 40 years or so, the two partners became estranged. This has impoverished psychiatry, both in its diagnostic and therapeutic efforts. The WPA Section on Religion, Spirituality and Psychiatry wants to bridge that gap and enhance renewed rapprochement, by continuing and stimulating discussion about this topic and by promoting research. Psychiatry, religion and spirituality show consanguinity. Neglectfulness of this kinship is detrimental to both parties.

"There is a growing awareness in clinical medicine of the imperative to consider the wholeness of individual persons (health professionals and patients) and to cross more frequently the boundaries between spirituality, religion and psychopathology. The practice of community psychiatry in multi-faith, multi-racial populations will challenge psychiatrists to consider their own belief patterns. The educational, research and conceptual implications of these new developments in world psychiatry should now be given a renewed priority" (Cox & Verhagen, 2011, p. 148).

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Chapter 3

The case for more effective relationships between psychiatry, religion and spirituality[1]

Introduction

In 2009 and 2010, three groups of editors published volumes on religion, spirituality and psychiatry (Huguelet & Koenig, 2009; Sims & Cook, 2009; Verhagen, Van Praag, López-Ibor, Cox, & Moussaoui, 2010). These groups consisted of representatives from well-known mental health institutions (in Geneva, Switzerland and in Durham, NC), members from the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists (London), and representatives of the World Psychiatric Association (WPA) Section on Religion, Spirituality and Psychiatry.

These groups of editors succeeded in bringing together an amazing amount and depth of scientific knowledge, experience and clinical wisdom. Of course, this was not the first time that books like these have been published. In that sense, the topic could be as self-evident as any other topic in psychiatry and mental health. The opposite is true.

The old song over again

In most cases, research papers on psychiatry and religion conclude that religion is important for a majority of patients. Although this is a known fact, psychiatrists often underestimate the impact of religion, disregard the topic or do not initiate discussion of this topic (often due to lack of

1 Published as: Peter J. Verhagen. *Current Opinion in Psychiatry*, 2010 [Special section]*, 23*(6), 550–555. doi:10.1097/YCO.0b013e32833d8b04

time, or feeling insufficiently prepared). The story about psychiatrists' neglect of and even hostility against religion and spirituality has been told many times, again and again.[2] In a sense, given the available knowledge and research data, it is an outdated and unprofessional story and may even be unethical. Unfortunately, it continues today as shown by the attitude of psychiatrists in general. Could this neglect be caused by the psychiatrists' lack of time and the feeling that they are insufficiently prepared to deal with this topic (Borras, et al., 2010)? Lack of time usually means lack of priority. And a justification based on lack of knowledge is not professional at all. After all, that is why psychiatrists engage in continuous education and skills labs. In fact it seems as if many psychiatrists even feel they are strengthened in their views which they base on new theorizing. Religion and spirituality are no longer rejected following old fashioned–as we know now–(orthodox) psychoanalytic and anthropological views. In the last 10-15 years evolutionary biology, cognitive psychology and neuroscience have not only increasingly elucidated the neurological and psychological mechanisms underlying human functioning and mental health, but have also more or less vehemently declared religious and spiritual explanations superfluous, e.g., that they are a by-product of cognitive functions (Fingelkurts & Fingelkurts, 2009; Kanazawa, 2010; Kapogiannis, Barbey, Su, Krueger, & Grafman, 2009; Tremlin, 2006; Urgesi, Aglioti, Skrap, & Fabbrio, 2010;), and even toxic (Abu Raiya, Pargament, & Magyar-Russell, 2010). The insinuation that religion is an opiate has been replaced by the accusation that it is poison. In the meantime theologians and philosophers of religion are becoming more and more involved in constructive exchanges of ideas with this "new atheism" and rethinking theological topics (Dodds, 2009; Fergusson, 2009; LeRon Schults, 2008; Murphy, 2009; Reiss, 2009). Indeed, discussions seem to have drifted away from psychoanalytic discourse to "brain-talk". As happened before, in general common theorizing is very often an oversimplification of complex theories, and is characterized by taking large steps to reach the destination more quickly.

However, we should not split into opposing camps to the detriment of psychoanalysis. Psychoanalysis has developed itself into one of the

2 This issue is elaborated on in Chapter 2, particularly on pp. 29-31, including references; see also Chapter 5, p. 101.

most fruitful contributors to the psychology of religion. The description of casuistry, especially the transference-countertransference issues, continues to be highly instructive (Aron & Henik, 2010; Holliman, 2009; LaMothe, 2009; Litmaer, 2009; Peteet, 2009). And in recent years we have seen cross-corroborations not only between psychoanalysis and the psychoanalytic psychology of religion, but also involving disciplines that previously considered themselves of a totally different nature: neurobiology, cognitive science and evolutionary psychology. That is interesting and promising enough. Another question is whether a century of psychoanalytic psychology of religion has made any progress. According to Van Belzen (2009) there is no unambiguous answer to this. He does make an important statement. Modern scientists of religion demonstrate a tendency that previously was criticized in Freud: the tendency to discuss religion as such, as a macro level phenomenon.

Would it be disadvantageous if the old song were to be repeated continuously? According to the "Manual of Procedures" of the World Psychiatric Association that if "the absence of an expressed consensus on a particular issue may lead to decisions or practices harmful to psychiatry or to persons suffering from mental disorders", the preparation of a Consensus Statement should be considered.[3] The WPA Section on Religion, Spirituality and Psychiatry has stated the time and again that time has come to decide to produce such a statement. A preliminary draft has been published to get discussions started (Verhagen & Cook, 2010).

Religious diversity: Incommensurability

As always, perhaps most of the time from a Western perspective, we try to define the concepts we use, concepts such as mental health, religion and spirituality. At the same time we somehow do not seem to reach complete scholarly consensus, despite many well-considered efforts. We usually explain this as a discontinuous process due to the

3 This is a quotation from the WPA Manual of Procedures Fourth Edition ([n.d.], p. 64). This edition of the manual is no longer available. It was replaced by the Fifth Edition, 2018. See the WPA website: www.wpanet.org

multifaceted aspects of the concepts just mentioned. However, the question could be asked, and is not asked very often, whether it would be possible and necessary to find such strived after consensus. As a matter of fact it is even more compelling to ask whether a unifying definition of religion is possible in principle.

Let us briefly have a closer look at the concept of religion (Lehmann, 2009). Not only is the etymology of the word still debated, the language of the Old Testament has no word for it, and the factual modern concept as it is used in the Western world is not as self-evident as it is assumed. In the Eastern world a construct like religion is practically absent and an effective equivalent is not available. Religion is not only a multifaceted construct, but religions show us enormous variations.

Recently Maat (2009) explained that it is almost impossible to give a definition due to this massive religious diversity. Definitions that try to cover all elements of every tradition are all too general and vague. Maat makes a distinction between religious pluralism and religious diversity. Religious pluralism is an approach of religious diversity. Religious pluralists argue that religious diversity has its limits. Ultimately, certain elements are common to all religious traditions. On the other hand critics of religious pluralism reject such a monistic approach and claim that religious diversity is irreducible.

The issue at stake here is the so-called "incommensurability". The term is not only used in the area of science (by Thomas Kuhn), but also in the domain of worldviews (by Paul Feyerabend; Maat, 2009, pp. 108-111). Incommensurability means is that a complete translation of theories or worldviews in each other's terms is not possible, and that there is no neutral language that overarches these theories or worldviews. It means that people use different standards for truth and rationality. Mutatis mutandis this reasoning also holds true with regard to religion (religious and spiritual traditions) and psychiatry and its theories. Incommensurability, however, does not mean obstruction of understanding and communication, although the attitude of psychiatrists towards religion seems to suggest it does. What we can do is to discuss and compare incommensurable theories and worldviews, because incommensurability does not imply unintelligibility. The inevitable implication would be the creation of multi-disciplinary workgroups, bringing together different perspectives, with expertise in religious experience and spirituality, in psychiatry and in philosophical fieldwork

(Fulford & Sadler, 2010). Service users should also take part in that kind of work.

The job of religion

William James (1842-1910), most famous for his *Varieties of Religious Experience* (1902/2002) and most influential as psychologist and philosopher in the study of religion, took a pluralistic stance and at the same time he believed in a core in religious experience across personal and religious traditions. This idea is called the "perennial philosophy" and is not uncommon nowadays for example among transpersonal thinkers (Nelson, 2009, pp. 117-123). The perennialists, dominant in psychological research of religious experience in the 1960s, were opposed by the constructivists, who dominated religious studies during the latter part of the 20th century. According to the constructivist position different religious traditions are inherently different and religious experience is not bound to a set of criteria like the set proposed by James (ineffability, noetic quality, transiency, passivity). In fact James' set induced a normative fixation on the exclusiveness and the extraordinary character of religious experience, which made it very rare. And as a consequence of this rareness, religious or spiritual experience became suspect to scrutiny for psychopathology; in a sense, it was guilty until proven innocent.

Religious experience is one of the major characteristics of religious involvement. Beliefs and practices are the other two. Religious experience is not that rare. Thirty to forty percent of respondents have had at least one or two religious experiences. Religious experiences can take ordinary forms. As summarized by Fingelkurts and Fingelkurts (2009), religious experiences provide a sense of patterning of events in a person's life by a divine being, an awareness of the presence of a divine being, an awareness of answer to a prayer, an awareness of being looked after or guided by a presence of God, feelings of positive affect, peace, joy, and unconditional love. In other words, religious experience is a religious interpretation of ordinary, daily experiences; therefore religious experience is not at all rare. On the contrary, religious people are trained to interpret their experiences in a religious way and they try to make sense of their lives and of their experience of the world by

understanding these in terms of the faith which has been handed down to them in the religious tradition. This "normality" of religious (and spiritual) experiences makes it likely that such experiences do occur and have meaning in the lives of many psychiatric patients and their relatives as well. The effect of these experiences in combination with religious beliefs and practices does not depend on the amount of evidence for it, but on the role they play in the life of the religious believer. Believers, whether Christian or not, demonstrate the truth of a religious truth claim by living up to it and showing their commitment to it (as Wittgenstein would have it said [Maat, 2009, pp. 133-135]). That also means that a religious believer cannot just believe whatever she or he wants. And the ongoing support of philosophical theology provides us formal and practical criteria for assessing religious (and non-religious) views of life: coherence, credibility, intelligibility, relevance and fruitful adequacy. Aside: full congruence between an individual's religious ideas, behavior, and practices is rare (Chaves, 2010).

Western psychiatry and cross-cultural perspectives

We have thus far considered several aspects that are relevant for psychiatry. In the first place the failure to define constructs in a consistent way is a recurrent key criticism of the research in religion and spirituality. Usually spirituality is defined more broadly, and religion or religiosity is limited to that which is formalized. And there is a lot of debate going on as to how these two relate to each other (separate domains, rivals, dimensions of the same quest) (Hackney, 2010; Verhagen & Cox, 2010). In addition cross-cultural research is hindered by the use of Western derived inventory measures of religiosity and spirituality, which until recently were based on reductive assumptions. In their introduction to a two-part series on Islamic Religiosity the guest editors Amer and Hood (2007) caution against bias in simply applying or modifying Western assumptions and techniques for Islamic (and other) religious populations. In the first issue of the two-part series Ghorbani, Watson and Haneef Khan (2007) develop a dialogical model of research in order to find an appropriate way out of these difficulties. The authors express their hope that such a model will foster a conceptual and empirical dialogue that will promote greater understanding of

religious and nonreligious perspectives instead of falling back into some form of reductionism of religious traditions to general conceptualizations. Such a greater understanding will find both universal and tradition-specific characteristics that should not be played off against each other (Nelson, 2009). Such a proposed dialogue obviously demands an interdisciplinary approach.

Cross-cultural research reports have repeatedly shown the limitations of the old-fashioned approach (Abdel-Khalek & Lester, 2007). Fernando carries the discussion to an even more critical level (2010). It would not only be "unwise" to think that Western ways of dealing with mental health and illness could be applied "in toto" outside the original culture. The risky part of the problem is not just a matter of its limitedness but of a possible destructiveness (Abu-Rayya & Abu-Rayya, 2009). Psychiatrists are told not to impose their own systems of beliefs on their patients (American Psychiatric Association, 2006). That should not only be the case in psychiatric practice but also in psychiatric (cross-cultural) research. The so-called cultural assessment and formulation constitute an important and very useful tool. Also fascinating are the research data on traditional healing and the unanticipated contributions of traditional healing and traditional psychiatric knowledge to mental health (Incayawar, Wintrob, & Bouchard, 2009; Moreira-Almeida & Koss-Chioino, 2009).

What will happen in DSM-V[4] (Peteet, Lu, & Narrow, 2010)? The task force allowed psychiatrists around the world to have a look at the new proposals. Until then, not a single word had been spent on religion and spirituality. However, the personality disorders section contained an interesting feature. It seems that DSM-V workgroup on personality has officially proposed to use Cloninger's model of personality to define healthy personality functioning, accepting the extensive data showing that healthy functioning is indicated by high self-directedness and high cooperativeness whereas personality disorders are low on both of these dimensions. However, they do not include high self-transcendence as part of what makes personality healthy. Of course spirituality is an expression of self-transcendence (or vice-versa) and Cloninger and colleagues have shown that it has strong effects: spirituality consistently increases positive emotion and elevates life by serving others

4 DSM-V became DSM-5.

selflessly. Does this omission indicate a continuation of the ignorance of the field (Cloninger, 2009; Cloninger, Zohar, & Cloninger, 2010)?

Conclusion: Good for your practice

This review will conclude with a few practical implications. The relationship between aspects of religiousness and spirituality, and negative and positive aspects of mental health have been examined in psychiatric research for a long time, and fortunately increasingly (Baetz & Toews, 2009; Blazer, 2009; Cox & Verhagen, 2011; Dein, 2010; Levin, 2010). Time and again issues worthy of consideration such as religious and spiritual needs and the place of spirituality in psychiatric care (Galanter, Dermatis, Talbot, McMahon, & Alexander, 2009; Koslander, Barbosa da Silva, & Roxberg, 2009) and nursing (Pesut, 2009; Reimer-Kirkham, 2009) are brought to our attention. There is a flow production of research focusing on the relationship between religion and/or spirituality and sociodemographic factors (Moreira-Almeida, Pinsky, Zaleski, & Laranjeira, 2010), mood disorders (Cruz et al., 2010; Dew, et al., 2009) and suicidal behavior (Rasic et al., 2009), anxiety (Siev, Chambless, & Huppert, 2010), psychotic disorders (Borras et al., 2007; Huguelet, Mohr, Gilliéron, Brandt, & Borras, 2010; Mohr et al., 2009), personality disorders, substance abuse (Agrawal & Lynskey, 2009; Moos, Schutte, Brennan, & Moos, 2010), trauma and coping (Schultz, Tallman, & Altmaier, 2010), refugee and immigrant mental health, the religious advisor's role (Kovess-Masfety et al., 2009) and globalization. Systematic reviews are available. Teaching in the psychiatric curriculum and continuing education help residents and professionals gain perspective on and develop skills in religious history taking and spiritual assessment (LoboPrabhu & Lomax, 2010; Verhagen & Cox, 2010), including differentiating non-pathological spiritual experiences from pathological experiences (Menezes & Moreira-Almeida, 2009; Moreira-Almeida, 2009).

Creative colleagues such as Koenig and others help professionals ask questions about religion and spirituality with acronyms such as

"FICA" and "HOPE".[5] And after taking a religious or spiritual history professionals must report their assessment. Formulating the relevant considerations, the clinician will evaluate the impact of the patient's religious and spiritual background and conviction on the patient's clinical presentation, on the course of the illness and on treatment. One of the tools currently available for this purpose is the previously mentioned cultural assessment according to DSM-IV (Rohlof, Knipscheer, & Kleber, 2009). Another approach would be to formulate the way in which religion and spirituality are constructive or destructive. A more idiographic narrative approach would be to look at the dynamics of religiosity and spirituality in the person's life.

Is religion bad for your health? Andrew Sims argues both in a personal and at the same time professional way that although they represent different world-views, they have much to gain from one another (Sims, 2009).

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5 FICA: F – Faith, belief and meaning; I – Importance or influence; C – (member of) Community; A – Address religious or spiritual needs in healthcare. HOPE: H – sources of Hope; O – Organized religion; P – Personal spirituality/religiosity and practices; E – Effects on healthcare and end-of-life issues. See Culliford & Eagger (2009), pp. 24-25; see also Chapter 4, p. 79.

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Chapter 4

Psychiatry and religion: Values, research data and professionalism[1]

Introduction: Outline

This review concerning the controversial issue of "Psychiatry and Religion" is based on three assumptions. (a) Religious or spiritual well-being is an important aspect of health. (b) Empirical evidence reveals a largely positive relationship between religiosity/spirituality and different indices of health. (c) Psychiatrists should be expected always to respect and be sensitive to the spiritual/religious beliefs and practices of their patients, and not to use their professional position for proselytizing or undermining faith.

We follow a thematic approach based on recent scholarly literature. In the first part we will explore the impact of modernization on religion and the culture in the Western world. In the second part we will evaluate the meaning of empirical research that has been done to investigate the relation between religion (or spirituality) and mental health. In the third part we will discuss the topics of attitude, professional practice and awareness.

We will find that (a) the European and World Values Surveys are very useful to understand what is happening to religion and to understand what is called the existential-psychocultural context in which Western people live; (b) By means of a representative meta-analysis of studies on religiosity and mental health the mixed results (positive and negative correlations) are shown and the difficulties, pitfalls and possible solutions exposed; (c) We will take spiritual history taking as a

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topic to illustrate the sometimes heated discussions, in order to find a way beyond outdated boundary thinking.

The overall conclusion will be that psychiatrists should cast off their distrust and acknowledge that it is a matter of professional practice to include religion and spirituality in patient care.

Three issues of controversy

The awareness of the meaning of religion, spirituality and meaning making in the lives of human beings in general and psychiatric patients in particular is taken more seriously now by healthcare professionals than before. The rise of this awareness is (closely) related to changes in the public realm. Religion and spirituality did not disappear but returned. The secularization hypothesis turned out to be an ideology showing us a lot about modern self-understanding and striving with disregard of religion and spirituality. However, whatever the empirical and conceptual flaws of the secularization hypothesis are, it is at the same time very clear that especially religion did not reappear as if nothing had changed. Obviously, and in that sense the secularization hypothesis is right at least in the western world, religion did lose its grasp on society. Was it not exactly that phenomenon of dominating society as core business of religion that estranged people from its meaning for daily life? In fact as early as at the beginning of the 19th century the history of psychiatry started with the differentiation of early mental health care from clerical dominance over (often not very humane) care for the mentally ill and disabled. The reappearance of religion in our time has nothing of regaining such dominance, although certain religious traditions in certain most often mono-religion societies still and again strive for such a total dominance.

If we follow the line of that differentiation of the religious realm from other realms it is very interesting and meaningful to learn how and where we can trace clues of religiosity and spirituality in the lives of ordinary people. That will be the first theme of this overview. We will have a look at the so-called European and World Values Studies based on research that has been done to find out how people think of certain issues, including religion. From the results maps were

produced, which can easily be found on the internet and which can be used to make new maps of data of choice.

It is not only this societal phenomenon and the public visibility of the reappearance of religion and spirituality that interests us here. There are several other reasons for the rise of new awareness of religion, spirituality and meaning making today. Given the development of psychiatry as a medical discourse the relationship with institutional religion has been a history of much adversarial debate and religion was often neglected by (academic) psychiatry. Medical-biological and psychodynamic discoveries at the turn of the 20th century replaced religious and moral problems as etiological factors with sexual drives and organic anomalies. Religion saddled people with unnecessary feelings of guilt and kept them in an unhealthy state of childish dependence. And it turned out that psychiatrists were less religious than the general population; the (for a long time unnoticed) risk of professional biases was and still is not hypothetical, to put it mildly. Although even in the harshest periods of conflict a tradition of "psychiatry and religion" survived through the years.

That marks the transition to our second theme. From the 1980s of the last century on the scenery started to change. Certainly, although not clarified yet, this change concurs with the aforementioned reappearance of religion. Today an overwhelming amount of empirical evidence clearly demonstrates that stereotyped views of religion and prejudices like "If one learns that a patient is a believer, that patient's IQ will actually be rated 20 IQ points lower", are potentially harmful to the doctor-patient relationship (Fiselier, Van der Waal, & Spijker, 2006). Research clearly demonstrates that the story has more than just one negative side without denying that religion might have damaging effects on health and well-being. This will be the second theme of this review. Recently well-known international journals paid special attention to "psychiatry and religion": the *Asian Journal of Psychiatry*, the *Journal of Nervous and Mental Disease* and *World Psychiatry*. Without hesitation it should be underlined that the overall conclusion is that a majority of research indicates that religious individuals experience a transforming, a supportive, a health enhancing meaning of religion (Dein, Cook, & Koenig, 2012; Hackney & Sanders, 2003; Koenig, King, & Benner Carson, 2012; Pargament & Lomax, 2013; Verhagen, 2013). That does not contradict the fact that a lot of questions are still waiting

for answers and that methodological problems must be acknowledged and resolved. Dein, Cook, & Koenig (2012) are fair enough to admit that this area of study remains "in its infancy". And although the authors declare there is no conflict of interest it is a serious question whether disclosure of religious beliefs in case of controversial issues would be recommendable; according to discussants such as Sims and Cooper it definitely is (Cooper, 2009; Sims, 2009).

This brings me to the third issue of this overview on controversies in the relationship between psychiatry and religion. Understanding and addressing religious and spiritual issues should no longer be a matter of personal interest or preference on behalf of the professional. On the contrary, it is a matter of professional practice and professionalism. Recently, Gabbard and colleagues, among others, made it clear again that psychiatrists and other mental health professionals are involved in "values-based decisions of profound importance in the lives of patients" (Gabbard et al., 2012). And they take it as a professional challenge to build a therapeutic relationship with someone who is different in terms of belief systems. Psychiatrists and psychotherapists should be aware of unconscious prejudice, strive for cultural empathy, avoid erroneous assumptions about the other, and so on. Of course this is a matter of what is called cultural competence, but not just that. It also demands a clear view on how patients relate to their disorders and how these disorders affect the relationships of the patients to the disorders, and how the patients as persons affect that relationship. Parallel with this approach something similar can be said regarding the relationship of the professional to his professional role. The professional relates to his professional role, this role affects this relationship, as the person of the professional does. In both cases the person comes into view, including his and her personal existential, religious or spiritual views. In fact one cannot abstract from either of these relationships, not in the patient's case and not in the professional's case; it is the notion of the experiential dimension of selfhood that is at stake here (Glas, 2012). This will bring us back to the notion of awareness. It seems that the awareness of religious and spiritual issues in clinical practice is not self-evident. To counter such a blindness of the professional it is helpful to develop a skill of awareness to start with. Such a skill obviously starts with careful attention to the language used (Fulford, 2010).

Values: Two axioms

Let us now turn to the changing religious landscape of the modern world. I will summarize very briefly a few starting points based on the European and World Values Studies and then we will try to get a rough picture of certain religious values. In my view it is opportune for mental health professionals to be aware of these cultural changes especially with regard to religion and values since they themselves and their patients are part of it. Already in the 1990s Michel (1996) offered a very simple and yet significant figure to visualize the interaction between the personality of the patient and the personality of the therapist, and between the cultural identity of both. What we see is that this interaction is always determined by the relationship between these two individuals, the relationship of each partner to his or her own cultural group, the relationship of each partner to the other partner's cultural group, the wider relationship between both cultural reference groups, and the cultural context in which the session takes place. In this merger of interactions values and views interact in a complex way. Especially that wider relationship ("metatransference", as Michel called it) is of interest here, since neglecting it can be the cause of numerous interaction problems (e.g., conflicting values, pathologizing certain views of the patient on the part of the doctor). What can we learn about the current state of religious values in modern society?

Advanced industrial societies have been moving toward increasingly secular orientations during the second half of the twentieth century. At the same time more people worldwide, and their number is growing, have traditional religious views. In fact 90% of the world's population is involved in some form of religious or spiritual practice (Koenig, 2009). Part of the explanation of this contrasting figure is based on the security axiom (Norris & Inglehart, 2004). Advanced industrialized societies and less industrialized societies differ in their levels of human development and socioeconomic inequality. Both factors mean a significant difference in conditions of human security and vulnerability. Security within this regard is no longer focused on military strength only, but increasingly on environmental security. Human security is basic to well-being and critical to religiosity. And it is obvious that industrialization and modernization, from agrarian economies to moderate industrial societies to post-industrial societies have

brought better basic conditions and improved human security. That does not mean that modernization is not problematic. The so-called "container" model of society and its reliable institutions is changing. The normal family, the life-long career and full employment, the normal life history are all suddenly called into question (Beck, Bonss, & Lau, 2003).

Economic development is not the only condition to create human security. Socioeconomic equality is also critical for conditions of human security. At the same time it is important to realize that even in advanced societies secure conditions are not unassailable. Any crisis, as we see it today, can provoke a new phase of insecurity.

Human security is one basic building block for the explanation of the co-existence of secularization with the rise in the number of people who have religious views. Norris and Inglehart (2004) formulated a second axiom: "the cultural traditions axiom". It is clear that cultures of nations have been shaped by religious traditions for centuries. Many countries in Northern Europe still hold a protestant value system although a smaller minority of the public attends church. The same holds true for the impact of other religious traditions in other parts of the world. To give an example, it is clearly shown that Protestant religion still affects labor market outcomes. In that sense the Weberian view is supported. Feldmann analyzed the effect of Protestant religion on labor force participation and employment rates and found that the Protestant work ethic is still influential today (Feldman, 2007).

Based on these two axioms Norris and Inglehart (2004) formulated a few hypotheses and a research program. Two of these hypotheses do interest us here. The experience of growing up in a less secure society will heighten the importance of religious values. Obviously under the influence of modernization religious reassurance becomes less pressing. That does not mean however that belief systems are fading away. Secular ideologies also tempt people to follow such a view that promises that belief in life before death turns out well. Religion and secular beliefs reduce stress in the broadest sense of the word.

That is one part of it. The other is that religion is not just about life directing values, but also about cosmology. Modern life experience creates a wide gap between secular interpretations and traditional religious explanations of evolution versus creation, and development versus history. The second hypothesis is a consequence of the second

axiom. Although religious traditions imprinted culture for many centuries, that influence faded. However, it seems obvious that these same religious traditions are not as static as they are sometimes assumed to be. On the contrary, religious traditions seem to be able to adapt and to evolve in response to developments in the modern and post-modern world. Of course these changes will have consequences for the way people practice their religious views and civic engagement.

Values: Two dimensions

Let us now turn to the European and World Values Studies (EVS/WVS). These values surveys are the largest investigations of attitudes, values and beliefs around the world and are designed to provide a comprehensive measurement of all major areas of human concern, including religion. The data show that on the one hand economic development is associated with a shift away from traditional values; on the other hand it also becomes clear that distinctive cultural traditions persist. Based on the work of Inglehart it is shown that the differences between advanced societies and low-income societies across a wide range of values can be plotted along two dimensions: traditional versus secular-rational values and survival versus self-expression values (Inglehart & Baker, 2000; Inglehart & Welzel, 2010). These two dimensions explain more than 70 percent of the cross-national variance. According to the view of the authors on modernization the traditional versus secular-rational dimension reflects changes linked with the transition from an agrarian to an industrial society, associated with rationalization and secularization. The second dimension is linked with the level of existential security and with the transition from industrial to post-industrial or knowledge societies. When survival is less secure survival strategies are more in the foreground. When survival can be taken for granted other goals and values become important.

The traditional versus secular-rational values dimension reflects the contrast between societies in which religion is important and those in which it is not. In traditional societies God and religion (belief in heaven and in hell) are very important along with work, children must learn obedience and religious faith, absolute standards are emphasized (abortion, suicide, euthanasia, divorce are never justifiable) along with

respect for authority and national pride. And people describe themselves as "religious persons". Secular-rational values emphasize the opposite. The second dimension reflects the polarization between survival and self-expression values. Survival values are characterized by priority to economic and physical security over self-expression and quality-of-life. People who live survival oriented reject foreigners, homosexuals. Hard work is one of the most important things to teach children, imagination, tolerance and respect for others are not the most important things to teach children. And again, self-expression values emphasize the opposite.

Inglehart and Baker (2000) found evidence that orientations have shifted from traditional toward secular-rational values in almost all industrial societies. And when a society starts to become a knowledge society a new shift appears, from survival to self-expression values. Self-expression tends to interpersonal trust, tolerance, subjective well-being, quality of life and self -expression.

Values: European maps

Just to illustrate the findings of the EVS/WVS I have selected a few maps. A first map depicts the percentage of people who believe in a personal God.[2] In Western Europe that percentage is less than 27%, in the Netherlands it declined from 37% in 1981 to 24% in 2008. Compared to countries such as Italy and Spain there is a huge difference; in Italy 62% (2008) and in Spain 44% (2008). However, there is an interesting finding connected to this.[3] People were asked to rate which of the following statements came closest to their belief: (a) there is a personal God, (b) there is some God, spirit or life force, (c) I don't know if there is a God, spirit of life force, (d) there is no God, spirit or life force. First of all the percentage of people who responded that the statement there is no God, spirit or life force is closest to their belief is very low! However, in countries where the percentage of people who claim that belief in a personal God is closest to their belief is relatively low, the percentage of people who claim that there is a God, spirit or life force

2 See: http://www.atlasofeuropeanvalues.eu/new/europa.php?ids=1251&year=2008

3 See: http://www.atlasofeuropeanvalues.eu/new/europa.php?ids=1252&year=2008

is quite high. That must mean that despite what is said about the decline of religion the percentage of religious belief or spirituality is still high and wide-spread. Another map pictures the answers to the question "how important is religion in your life".[4] In Western Europe that percentage is in a range of 36%-51%, less in Sweden and Finland, higher in for instance Russia, Poland and Italy. If one looks at the world map on the same item one will find high percentages in Islamic countries, and also in South-America. A last map shows percentages of people who do gain comfort and strength from religion.[5] In countries like Belgium, Germany and the Netherlands (slight decline from 50% to 44% in 2008) that percentage is still within a range of 40%-54%, In the Scandinavian countries and the United Kingdom that percentage is lower, in Eastern Europe it is higher.

How to use figures like these values maps? A few examples can be traced, for instance on religion and suicide acceptability (Stack & Kposowa, 2011). DeMarinis (2007) published a paper worth reading, that is an illustrative example of what concerns us here. First she explains the cultural context of Sweden through World Values Survey research. Sweden, on the cultural mapping of values, represents the extreme combination of the secular-rational dimension and the self-expression dimension. The percentage of people who believe in a personal God is 15%, the percentage of people who claim that there is a God, spirit or life force is quite high, the percentage of people who say that religion is important in their lives is 22%, and 30% of the people say they gain comfort from religion. Second DeMarinis developed a "Swedish Existential Worldview Typology", by which she means a typology of worldviews based on narratives about life's meaning and the actions of ordinary persons confronted with life's unruliness. These narratives together with values and ritual behavior function as resources in time of hope and crisis. Third based on this typology she formulates the challenges and opportunities to include an existential assessment as a quality aspect of public health (wellbeing, prevention, intervention), an exciting look at existential public health and health care.

4 See: http://www.atlasofeuropeanvalues.eu/new/europa.php?ids=6&year=2008

5 See: http://www.atlasofeuropeanvalues.eu/new/europa.php?ids=130&year=2008

Another approach using data from the European Study of the Epidemiology of Mental disorders (ESEMeD) study showed differences in consulting religious advisors for mental health problems related to the degree of religious involvement per country (Kovess-Masfety et al, 2010).

Intermezzo I

The maps do not show us how the values relate to the two dimensions traditional versus secular-rational and survival versus self-expression. If one looks at the maps as shown by Inglehart and Welzel (2010) one will see that Protestant Europe is located in the secular-rational/self-expression quadrant. Catholic Europe and Latin America are essentially located in the middle, but Catholic Europe is more on the secular-rational side, Latin America on the traditional side. Africa is located in the traditional/survival quadrant. So we have to find out what the percentages we found mean in the light of the localization of countries on the global cultural maps. In fact it does not say much about the individual let alone the psychiatric patient. However, it is also clear from these data that religious values leave a lasting imprint, although in changing forms and practices. Individuals always adapt and transform religious practices in relation to received institutional forms. Religions, by offering promises of health, prosperity, and salvation can address the new crises of our lifetime that secularization, modernization and technologization have created. Religions did not disappear but have adapted to these new conditions. And it must be that "their continuing appeal lies in this adaptability, this capacity to renew and represent the possibility of extra-human empowerment in response to continuing human experiences of vulnerability" (Konienczny, Lybarger, & Chong, 2012). Therefore religions will continue to be a vital source in contributing to a person's worldview; they influence the kind of coping behaviors and influence decisions and choices that lead to moral actions and development of human virtues. Therefore Dein and colleagues are right when they state on the one hand that religious studies in the broadest sense of the word address a broad range of inquiry including the impact of religious views on norms and values, meaning and purpose of life, identity and self-understanding, and grounds for hope and despair, and on

the other hand that too few of these studies are taken into account in psychiatric practice and training. The World and European Values Studies are an example of this state of affairs (Dein et al., 2012).

Meta-analysis: A representative example

"Extensive research has been conducted and comprehensive data are available, but the relationship between religion, spirituality and mental health is still disputed. Indeed, there are some clear examples of a negative effect of spirituality or religion on mental health. Nevertheless, a majority of experts seem to agree that in general the relationship [between religion, spirituality and mental health] can be qualified as positive" (Verhagen & Cook, 2010, p. 620). A preponderance of studies indicates that religious individuals fare better than their secular counterparts in psychological disorders. Koenig and his colleagues can be regarded as the champion in collecting and evaluating research. In the first edition of the *Handbook of Religion and Health* Koenig and colleagues showed that 476 out of 724 quantitative studies before 2000 reported a positive association between religious involvement and a wide range of indicators for mental health. They demonstrated that religious involvement was correlated with various mental health states, such as well-being, happiness, life satisfaction, hope and optimism, purpose and meaning in life, higher self-esteem, adaptation to bereavement, greater social support and less loneliness, lower rates of depression and faster recovery from depression, lower rates of suicide and fewer positive attitudes toward suicide, less anxiety, less psychosis and fewer psychotic tendencies, lower rates of alcohol and drug use or abuse, less delinquency and criminal activity and greater marital stability and satisfaction (Koenig, McCullough, & Larson, 2001, pp. 214-220; see also Koenig, 2009). In the second edition studies are added that were conducted between 2000 and 2010 (over 2.100 quantitative studies: Koenig et al., 2012). The picture has been confirmed by these studies since 2000.

Instead of summarizing studies I would like to look in some detail at one of the often cited meta-analyses, the study done by Hackney and Sanders (2003) of then recent studies on religiosity and mental health (see also Hackney, 2010). One of the main difficulties and an arena for

disagreement is the fact that researchers deploy diverse definitions of scales of religion, spirituality and mental health. Religion, spirituality and mental health are multidimensional constructs and we still wrestle with a lack of (scholarly) consensus on how to define these constructs. The authors I am referring to solved the problem in a rather elegant way. They looked at the way religion and mental health were defined in the studies they included (35 studies between 1990 and 2001) and developed a classification scheme along the following lines. Definitions found in these 35 studies that focused on the social and behavioral aspects of religion (e.g. attendance of services, participation in church activities) were coded as "institutional religion". Definitions that focused on beliefs involved in religious activity (e.g. ideology, attitudes, belief salience, and fundamentalism) were coded as "ideological religion". Definitions that focused on personal, internalized devotion (e.g., emotional attachment to God, devotional intensity) were coded as "personal devotion". This classification scheme reminds us of other proposals and recommendations to the use of a multidimensional construct of religiosity (Table 1).

Table 1: Examples of dimensions of religion in the course of time[6]

Dimensions of religiosity			Application
Glock (1962)	*Wulff (1991)*	*Braam et al. (2003)*	*Hackney & Sanders (2003)*
Ritual	Traditional	Behavioral	Institutional religion (attendance, extrinsic orientation, ritual prayer)
Ideological		Cognitive	Ideological religion (ideology, attitude, salience of belief, fundamentalism)
Intellectual			
Experiential	Mystical/Moral	Affective	Personal devotion (intrinsic orientation, emotional attachment to God, personal prayer)
Consequential		Motivational	

6 After Braam (1999, p. 10).

The variation offered by the sociologist Glock (1962) was for a long time a dominant model. Wulff reduced Glock's five dimensions into two categories. Recent research has shown that Islam – like Christianity, Judaism and Hinduism – is multidimensional as well (Abu-Raiya & Pargament, 2011).

Hackney and Sanders also coded definitions of mental health or psychological adjustment. Definitions focusing on the unhappy aspects of mental health (e.g. depression, anxiety) were coded a "psychological distress". Definitions that focused on positive feelings regarding the self and one's life in general (e.g., self-esteem, happiness) were coded as "life satisfaction". Definitions of psychological adjustment focused on the more growth oriented and humanistic aspects of mental health (e.g., identity integration, existential well-being) were coded as "self-actualization".

The authors found 264 effect sizes, only 78 of them were negative; most of them near zero or non-significant. The results showed that variation in definition or type of religiosity is one systematic source of variation in the effect sizes. The results also showed that the religiosity main effect took the form of significant increases in mean effect size as one proceeds from institutional religiosity to ideology to personal devotion. Also the variation in definitions of mental health is a source of systematic variation. The main effect took the form of significant increases in mean effect size as one proceeds from definitions centered on low psychological distress to life satisfaction to self-actualization. The authors also focused on the issue of interaction between types of religiosity and types of mental health. For example, when religiosity is defined as personal devotion a very slight increase in mean effect size from lack of distress to life satisfaction is followed by a large increase as one proceeds to self-actualization.

To summarize, regardless of any consideration of religiosity or mental health definitions religiosity may be said to have a moderate positive overall, helpful, salutary relationship with mental health; a consistent finding over the years. Allen Bergin was one of the first to publish a meta-analysis, back in 1983, when he set the tone (Bergin, 1983). At the same time each position that has been taken in the debate is supported: positive relationships (between personal devotion and self-actualization), negative relationships (between institutional

religion and psychological distress), and non-significant (between ideological religion and psychological distress).

It is interesting to note that this positive correlation between personal devotion and self-actualization comes forward. Hackney and Sanders (2003) explain that in their view it seems necessary to be a "true believer" (p. 51). That is to say, one has to accept and to internalize the worldview as one's own. A worldview becomes existentially relevant to the adherent in that sense. In that case religious involvement is based on personally chosen and valued beliefs (see also Abu-Raiya & Pargament, 2012). That brings us back to the values dimensions we discussed in the first part of this overview. Probably most of the 35 studies Hackney and Sanders included were done in Western countries, in Europe and North America. The results and classification formulated by the authors seem to fit in the picture of a shift toward the self-expression and quality of life pole of the survival versus self-expression dimension of values. Mental health and religion concepts turn out to be formulated in the mirror of one's own time.

Intermezzo II

The Netherlands Mental Health Survey and Incidence Study-2, a psychiatric epidemiological population study, showed that being religious was protective for mood disorder (De Graaf, Ten Have, Van Gool, & Van Dorselaer, 2012). Miller and colleagues published the first long-term outcome study on the impact of religion or spirituality on the emergence of major depression using a 10-year prospective longitudinal design (Miller et al., 2012). Conclusion: A high self-report rating of the importance of religion or spirituality may have a protective effect against recurrence of depression, particularly in adults with a history of parental depression. A very interesting English national study supports the mixed findings: Religious people do not differ from people who are neither religious nor spiritual with regard to the prevalence of mental disorders. Spiritual people turned out to be more vulnerable to mental disorder compared with those who were neither religious nor spiritual. The authors draw an interesting conclusion: spiritual beliefs without a religious framework make people vulnerable to mental disorder (King et al., 2013). And very important, studies on Islam, a

multidimensional religion, and mental health have reached comparable conclusions as in other religions although empirical studies are scarce (Abdel-Khalek, 2011a; Abu-Raiya & Pargament, 2011). A meta-analytic review on the relationship between spirituality and religiosity on psychological outcomes in adolescents and emerging adults showed a robust correlates on outcome variables of reduced risk behavior, reduces depression, and increased self-esteem and well-being (Abdel-Khalek, 2011b; Yonker, Schnabelrauch, & De Haan, 2012). We could go on. Time and again the question has been asked what these outcomes mean for clinical practice, psychiatric evaluation, training and research (Baetz & Toews, 2009; Blazer, 2012). Awareness of the literature is a necessary condition; an awareness that needs to be enhanced. Professionalism is the principal point! And religious competence belongs to cultural competence (Whitley, 2012). "Whatever disagreements there might be on definition, spirituality and religion are concerned with the core beliefs, values and experiences of human beings. A consideration of their relevance to the origins, understanding and treatment of psychiatric disorders should therefore be an integrated part of clinical and academic psychiatry. Spiritual and religious considerations also have important ethical implications for the clinical practice of psychiatry" (Verhagen & Cook, 2010, p. 630).

Professionalism: Attitude

In 2008 a discussion was started that reached a tentative conclusion with the publication of a special issue of Mental Health, Religion & Culture for January-February 2011, entitled "Psychiatrists views on the place of religion in psychiatry". The discussion was started, not to say provoked by Harold Koenig. And perhaps the discussion would not have started if not the president of the Royal College of Psychiatrists at that time had written a supportive commentary.

Koenig published, I assume by invitation, an editorial in the British *Psychiatric Bulletin*, nowadays *The Psychiatrist* (Koenig, 2008). In fact what Koenig described and proposed was not so new; he has written many editorials with the same tenor. His title: "Religion and mental health: what should psychiatrists do?" Note that the question is not "what should psychiatrists know?", but "what should psychiatrists do?"

I take it for granted that Koenig formulated the question that way on purpose and not accidentally. As if he were to say: What psychiatrists should know, should be known by now since that knowledge based on research and clinical experience over the last 25-30 years is completely available to every professional who has access to scientific and clinical resources. Koenig himself, as we have seen already, contributed a great deal to facilitate the exchange of ideas, clinical experience and research data. It should be professional knowledge by now that during the past 30 years systematic research has accumulated and that research does not confirm the connections between religious involvement and neurosis. The vast majority of studies reported statistically significant positive associations between religious involvement and a wide range of mental health indicators. So the question is not what psychiatrists should know, because what they should know should be known for many years now. The question is what should be done. What should psychiatrists bring into practice?!

However, again, what Koenig suggested was not completely new, and the key points had been made before. The key points are: taking a spiritual history, respecting and supporting beliefs, challenging beliefs, praying with patients ("in highly selected cases"), and consultation with clergy. A heated response was the result. Why?

Taking a spiritual history

I will confine myself to the point of spiritual history taking. Many colleagues around the world, including members of the Royal College Spirituality and Psychiatry Special Interest Group, have formulated the idea of taking a spiritual history likewise. By taking a spiritual history the psychiatrist should gather information about the patient's religious background or spirituality, and their experiences during childhood, adolescence and adulthood. Next the psychiatrist should "determine what role religion played in the past and plays in coping with" psychiatric illness (Koenig, 2008, p. 202). We are used to the experience that a lot of things are difficult enough to talk about in private, not to mention with strangers. It is even said that it is more difficult and intimate to talk about one's religious or spiritual life than about one's sexual experiences. Psychiatrists are trained in interviewing, and they are well

aware of the domains that should be assessed. And there is no reason why religion or spirituality should be excluded from such an approach. "Religious beliefs and activities important to patients should be explored, as well as their membership in a religious community, how active they are, how much support they receive, and whether this community is likely to oppose their psychiatric treatment. The information learned from a spiritual history will help to determine the therapist's approach to the patient's beliefs (whether supportive, neutral, or challenging)." (Koenig, 2008, p. 202).

It is not unusual, depending on the patient's problems, to conduct a more global assessment in this or that domain and more in-depth assessments in other domains. Depending on the information gathered the interviewer will proceed from global to more in depth assessment. This strategy is of course also very useful with respect to religion and spirituality. It is therefore helpful to make a distinction between a more global and an in-depth investigation. And as with other domains or content regions a global assessment is in fact always indicated. Questions that include: What is the patient's worldview? Which role did religion or spirituality play in the patient's childhood? In what way is the patient currently involved in religion or spirituality? Does the patient think his or her religious or spiritual beliefs and lifestyle are contributing to the problems, concerns, and symptoms in any way? Does the patient has any religious or spiritual concerns? Does the patient expect his or her religious or spiritual concerns will be addressed in therapy? Would the patient expect his or her beliefs and religious community to be helpful and a source of support? Koenig proposed screening questions known by the acronym FICA: Is Faith an important part of your life? How has your faith Influenced your life (past and present)? Are you a member of a religious or spiritual Community? Are there spiritual needs that you would like to Address? (Verhagen & Cox, 2010, p. 603).

Intensely held religious beliefs can conflict with the type of therapy chosen, including psychopharmacology, and doom that method to failure; negative attitudes toward traditional therapies are not uncommon among devoutly religious patients. And indeed the same applies to antidepressants or other drugs, where religious attitudes may adversely affect compliance and treatment follow-up.

During a global assessment one wants to elicit the information necessary to decide whether a more in depth interview will be appropriate and necessary. Several possible indications for such a more in depth approach must be considered (Verhagen & Cox, 2010):

- The patient's religious or spiritual background obviously seems relevant to the understanding of the complaints and problems.
- Religiosity or spirituality may influence the development and course of complaints and symptoms in a positive and/or in a negative way.
- Religiosity and spirituality may influence the choice and course of treatment or psychotherapy.
- Religiosity and spirituality may influence the explanatory models of illness and therapy.
- Religiosity and spirituality may cause problems that require clinical attention and care as such, because of unresolved conflicts, concerns, etc.
- The influence that religion and spirituality may have could be a reason to refer to, or to consult with a religious or spiritual caregiver.
- A religious or spiritual assessment could help to determine whether religious/spiritual interventions would be helpful.
- Religious and spiritual beliefs and concerns may be a critical component in suicide assessment.
- An understanding of moral codes and values in relation to a variety of aspects of human relationships and ethics may, again, have an impact on the choice of a therapist and on the choice and course of any treatment (p. 603).

In other words, an assessment is needed to understand the prognostic value of the patient's religious and spiritual involvement, to understand the life context of the patient, to monitor outcome, and to develop appropriate interventions.

Professional rules and boundaries

So far so good. However, Koenig (2008) did not stop here. He continued his proposal by saying that "[E]ven if the patient is not religious the

psychiatrist should gently probe further to obtain a better understanding of the patient's prior, if any, experiences with religion. Experiences that may have turned the patient off religion (…) could be contributing to current psychiatric problems. If the therapist meets firm resistance from the patient, the topic", according to Koenig, "should be tactfully dropped and perhaps approached at a later time after a therapeutic alliance has developed" (p. 202). Again, Koenig's plea was not new.

However, there is a big but. There is very little research on spiritual history-taking. Does it make a difference? What are the effects on the doctor-patient relationship? Is it worth the time (cost-benefit ratio)? A study among 147 outpatients of a psychiatric clinic in Geneva showed that a quarter of the patients wished the psychiatrist to address spiritual issues (Hefti, 2011; Mohr, 2012). Another study was conducted to assess the effects of a spiritual history in 118 oncology outpatients. The intervention group was compared to a usual care control group. The intervention was not only acceptable for the majority of the patients, well-being increased more in the intervention group (Kristeller, Rhodes, Cripe, & Sheets, 2005). It does not seem to be too difficult to do more of that kind of research.

What caused the heated response among Royal College of Psychiatrists members as expressed by Poole and colleagues in 2008? What was and still is the main concern? The suggestion that psychiatrists should routinely take a detailed spiritual history, even if the person resists, seemed to Poole and colleagues intrusive and excessive, even disrespectful to those who find meaning within beliefs that reject the transcendent and the supernatural. And according to the critics Koenig's proposal is a breach of formal codes of clinical practice (Poole & Higgo, 2011). For instance a professional rule formulated something like "You should not normally discuss your personal beliefs with patients unless those beliefs are directly relevant to the patient's care. You must not impose your beliefs on patients, or cause distress by the inappropriate or insensitive expression of religious, political or other beliefs or views. Equally, you must not put pressure on patients to discuss or justify their beliefs (or the absence of them)" (General Medical Council [GMC], 2008, p.2; quoted by Poole & Higgo, 2011, p. 24). According to Poole and Higgo, even if Koenig's recommendations are acceptable in the American context, they are certainly not acceptable in the British context. If we look at the World Values Surveys maps it is

true that there is a remarkable difference between the American and British context. Both countries are on the self-expression side of the survival versus self-expression dimension, but America is more on the traditional side and Britain on the secular-rational side of the traditional versus secular-rational dimension (Inglehart & Welzel, 2010). And yet, when Poole and Higgo (2011, p. 24) use expressions such as not to impose beliefs on the patient or cause distress, it is immediately clear that this is also not acceptable in the American context as appears from the *Guidelines regarding possible conflict between psychiatrists' religious commitment and psychiatric practice*; the psychiatrist should always respect and never impose (American Psychiatric Association, 1990). So there might be cultural differences with regard to religion, nevertheless these two principles are agreed upon on both sides of the ocean. Moreover Poole and Higgo (2008) do not explain how the professional rule they put forward relates to another one. Indeed, according to the GMC:

> Patients may find it difficult to trust you and talk openly and honestly if they feel you are judging them on basis of their religion, culture, values, political beliefs or other non-medical factors. For some patients, acknowledging their beliefs or religious practices may be an important aspect of a holistic approach to their care. Discussing personal beliefs may, when approached sensitively, help you to work in partnership with patients to address their particular treatment needs. You must respect patients' right to hold religious or other beliefs and should take those beliefs into account where they may be relevant to treatment options. However, if patients do not wish to discuss their personal beliefs with you, you must respect their wishes. (quoted by Cook, Powell, Sims, & Eagger, 2011, p. 39)

Here we run into the discussion of a professionally, morally (and also theologically) significant point. As I stated before, the interaction between doctor and patient takes place within a wider cultural context. Therefore the meeting is far from a value-free encounter. What kind of values are characteristic in mental healthcare? In the late 1990s an analysis of Dutch ambulatory mental health care showed that the following values prevailed implicitly or explicitly (Vandermeersch, 1996): autonomy, enjoyment of life, authenticity in personal relation-

ships, sexual identity as a personal challenge and composition of life, and the ability "to consider to be true" (Vandermeersch [1996] explains: One is expected to puts one's trust in knowledge, in proven facts, and in experts on issues one cannot investigate oneself. [p. 27]). The issue at stake is that however valuable these values cannot be seen without the context of twenty centuries of Western Christianity. That did not mean a simple translation, a kind of new wine in old wineskins. On the contrary it meant a more or less explicit critique of religion, which is quite easy to understand once one has been notified. And in that sense these values and the way they were understood perfectly go with the secular-rational and self-expression values. If we take these values as more or less characteristic for mental health care today (One could compare these five values with list of values embodied in DSM, as explained by Sadler, 2005), just for the sake of argument, it becomes clear that the way of reasoning put forward by Poole and Higgo (2011) does not hold up. They claimed that ever since the Enlightenment science and religion have operated within different domains. And that psychiatry as an applied science should operate from such a neutral secular position. I am afraid that such a separation only exists in the mind of certain psychiatrists and other mental health professionals, but not in the mind of (at least some of) the patients. It is part of the wider cultural development we already met: modernisation, characterised by increasing specialisation, the separation of means and goals, the separation of facts and values and the subjective from the objective. Psychiatry developed its own language of description and classification and, later, a model of disease similar to the somatic disease model. Psychiatry became associated with the objective, morally neutral application of scientific knowledge and religion was transferred to the realm of mere subjective appreciation and strictly personal choice.

There is a significant difference between "taking into account" religious factors on the one hand, and "taking them on" as objects of interventions on the other hand (Shuman & Meador, 2003, p. 24). Even Poole and Higgo (2011) admit that "taken into account" as mentioned in the GMC, belongs to "a detailed and sophisticated understanding of patients' lives", as they put it (p. 22). Koenig and many others go a step further and don't hesitate to take on religious or spiritual factors. Psychiatrists and other mental health professionals must be aware of their positions on a personal and a professional level instead of hiding

themselves behind some sort of scientism. And to be sure, theological claims based on the research we found are most certainly beyond the purview of epidemiological research or clinical practice. What we must do in the meantime is important enough but not new at all (Cook, 2011a, p. 15):

- Explore how one's own religious/spiritual beliefs may or may not coincide with those of the patient.
- Identify when religious/spiritual beliefs facilitate or obstruct the doctor-patient relationship.
- Become able to engage and to be comfortable with the deepest level of personal experience which embodies religiosity and spirituality.
- Discern when spiritual concerns are best dealt with within the doctor-patient relationship and recognizing when additional pastoral care is required.

In terms of competencies this means that a psychiatrist should (a) be able to inquire into the religious and spiritual life of patients, because (b) information about religious and spiritual life often reveals important information. (c) The assessment must communicate respect and curiosity for this dimension of the patient's life, (d) without pushing a personal agenda on the part of the professional.

Intermezzo III

Did the attitude of psychiatrists and other mental health professionals change over the years? Some interesting data are available. Curlin and colleagues did a survey among practicing U.S. physicians including psychiatrists. They asked them about their beliefs and observations with regard to the relationship between religion/spirituality and patient health and about the ways in which they address religion or spirituality in clinical practice. The results show that psychiatrists are more likely than other physicians to address religion or spirituality in clinical settings, they are more likely to believe that it is appropriate to inquire about a patient's religion or spirituality, especially when patients suffer from anxiety or depression. Just a minority reports sharing their own experiences. Barriers to addressing religion or spirituality are not

general discomfort or concerns about offending the patient, but lack of time, insufficient knowledge and training, and concerns about disapproval from colleagues (Curlin et al., 2007a). The same authors reported in another survey of the same group that compared with other physicians psychiatrists are less likely to be religious in general, and more likely to consider themselves spiritual but not religious.

Table 2: Ten Key Pointers of values-based practice (Fulford, 2010, pp. 48-49)

Practical skills

1. Awareness: of the values present in a given situation.
2. Reasoning: using a clear reasoning process to explore the values present.
3. Knowledge: of the values and facts relevant to the specific situation.
4. Communication: combined with the three previous skills, this is central to the resolution of conflicts and the decision making process.

Models of service delivery

5. User centered: the first source for information.
6. Multidisciplinary: conflicts of values are resolved by working towards a balance of different perspectives.

VBP and evidence-based practice

7. The "Two-Feet" principle: all decisions are based on facts and values.
8. The "Squeaky Wheel" principle: we only notice values when there is a problem.
9. Science and values: increasing scientific knowledge creates choices in health care, which introduces wide differences in values.

Partnership

10. Partnership: In VBP decisions are taken by service users and the providers of care working in partnership.

Non-psychiatrists physicians who were religious were more willing to refer patients to clergy members or religious counselors and less willing to refer patients to psychiatrists or psychologists. That would mean that the old tension between religion and psychiatry continues to shape the care that patients receive for mental health (Curlin, et al., 2007b). Of course we must know much more about how these same issues developed in other countries.

There is more to say about this. Attitude demands skills. Values-based practice (VBP) offers psychiatrists an excellent method to develop skills needed for working with complex and conflicting values in psychiatry (Fulford, 2010). Four main skills ask for training: awareness, reasoning, knowledge and communication skills. Actually Fulford explained the way of reasoning several times with the help of the story of Simon, a man who experienced a series of revelations. Table 2 gives the ten key elements of the process of values-based practice. VBP provides a way of resolving the stalemate in the conflict between natural sciences and the social sciences, between the physical sciences and the sciences of the mind. This dichotomy is false and the resolution has to come from a so-called normative practice model and a normative sense of professionalism in which moral and existential resources count.

Conclusion

Discussing "Psychiatry and Religion" we found that consideration of (a) cultural factors and context, (b) research outcomes and difficulties with measurement, (c) clinical application of the results and (d) a normative sense of professionalism beyond false dichotomies is of utmost importance. Nevertheless times have changed (Levin, 2010; Verhagen, 2012). Ongoing research is promising, but still a lot of questions remain to be answered. Yet it appears to be possible to join efforts and to bring together clinical experience and research data in a thoughtful way. Our patients will benefit from a new and sensitive approach and direct attention toward valuable aspects of their lives that have been neglected in psychiatric practice. Therefore it is important to value that (Verhagen & Cook, 2010; see also Cook, 2011b):

- Spiritual well-being is an important aspect of health;
- Empirical evidence reveals a largely positive relationship between religiosity/spirituality and different indices of health (….);
- A tactful consideration of patients' religious beliefs and spirituality should be considered as a valuable component of psychiatric history taking;
- An understanding of religion and spirituality and their relationship to the diagnosis, aetiology and treatment of psychiatric

disorders should be considered as essential components of both psychiatric training and continuing professional development;
- There is a need for more reserach (…);
- 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, and not to use their professional position for proselytizing or undermining faith;
- Psychiatrists, whatever their personal beliefs, should be willing to work with leaders/members of faith communities, chaplains and pastoral workers in support of the well-being of their patients, and should encourage all colleagues in mental health work to do likewise;
- 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 healthcare;
- Psychiatrists should, whenever appropriate, work for a better understanding between colleagues and patients of different religions and cultures, *bearing in mind that social harmony contributes to mental health and well-being* [emphasis added]. (pp. 630-631)

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Chapter 5

Religion and mental health
A critical reflection in consequence of four reviews (1969-2013)[1]

Introduction

Today professionals in the mental health professions (in particular in psychiatry, psychotherapy) are all familiar with reviews and meta-analyses according to the practice of evidence-based medicine and evidence-based psychiatry. This practice is very helpful because the number of empirical studies on our special field of interest has become enormous. The research on religion and mental health is no exception to this rule. Important and informative reviews are available. For example, the second edition of Koenig's *Handbook of Religion and Health* published in 2012 year is not just an updated version of the first edition published in 2001 (Koenig, King, & Benner Carson, 2012; Koenig, McCullough, & Larson, 2001; Verhagen, 2013). It is in fact a second volume and together with the first edition both volumes cover more than three thousand empirical studies! So if one wants to have an overview of the field one should have a look at both of these volumes.

It is our aim to sketch the main line by discussing four reviews published between 1969 – 2013. The intention of this sketch is twofold. We want to highlight the improvements of this kind of research in the field of religion, spirituality and mental health. These improvements have contributed greatly to the discussions about religion and spirituality in psychiatry in a positive way.

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Table 1: Summary of four reviews of empirical studies on religion/spirituality and mental health

Four reviews/ meta-analyses	*Sanua 1969*	*Bergin 1983*	*Hackney & Sanders 2003*	*Bonelli & Koenig 2013*
Meta-analysis	-	+	+	+
Period	1928-1967 (no explicit reason)	1951-1979 (no explicit reason)	1990-2001 (explicit choice)	1990-2010 (explicit choice)
Selection criteria; Number of studies included	No selection procedure	Explicit procedure (a)	Explicit and consistent procedure (b)	Explicit and consistent procedure (c)
Categorization of studies theory based	5 domains (d)	Religion as religious involvement	Coding of six categories (e)	Religious/spiritual involvement related to diagnostic groups according to ICD-10
Quality of methods used in the studies found	Minimal description of methods	Analysis of effect sizes	Analysis of multiple effect sizes	Full assessment of quality (based on Cooper, 2010)
Level of evidence	-	-	-	+ (based on Bonelli & Wenning, 2010)
Conclusion	No empirical support for a positive correlation	Data's ambiguities ask for better specifications of concepts and methods	Depending on definitions different types and strengths of the correlations are found	The available evidence (good, some, insufficient, no) differs by psychiatric disorder

(a): at least one religiosity measure, at least one clinical pathology measure; (b): recency, statistics, concept of religiosity, mental health as psychological adjustment; (c): articles in psychiatric and neurological journals ranked in the top 25%, focus on psychiatric disorder; (d): religiousness and psychological adjustment, deviancy and religiousness, authoritarianism and religiousness, prejudice and religiousness, humanitarianism social values and religiousness; (e) religiosity: institutional religion, ideological religion, personal devotion; mental health: psychological distress, life satisfaction, self-actualization.

However, there is still much controversy around this theme. For a summary of characteristics of the four studies, see Table 1.

Secondly, based on ethics of evidence-based psychiatry, it is our intention to reflect on the impact of this empirical research on the understanding and meaning of spirituality for mental health. About this impact not much has been said yet. Is it only profitable? Or are there any objections? And if so, what kind of objections? We will see that criticism was already formulated from a theological perspective by Shuman and Meador (2003). The question was and is what kind of religion we are talking about.

The final question we want to answer is whether it would be possible to sketch scenarios of the requirements for research on religion and spirituality in psychiatry. Based on the certainties and uncertainties, the strengths and the weaknesses we have found, we will sketch four scenarios.

Sanua's 1969 review

One of the first reviews, from the pre-evidence based era, was published by Sanua in the *American Journal of Psychiatry* (AJP) in 1969. In fact he presented a quite original approach. He divided the studies he found according to five domains: religiousness and psychological adjustment, religiousness and deviancy, religiousness and authoritarianism, prejudice and religiousness, and religiousness and social values. He challenged the then common belief that religion would be a basis of sound mental health. And he claimed that he had not been able to find any empirical support for that claim. He concluded that religious education at that time did not seem to ensure healthier attitudes. He focused on the possible effects of religious education, and had to conclude that despite the fact that love is taught people tend to internalize the divisive role of religion.

It was a review from the pre-evidence-based era, and therefore the interpretation appears to be more or less opinion based in our eyes today; no quantitative analysis of outcome measures, no information concerning how and on which grounds studies were selected and included or not, and so one. Therefore this review seems quite questionable today. However, I guess his conclusion fitted very well in with the

spirit of the 1960s. Sanua stated: "The contention that religion as an institution has been instrumental in fostering general well-being, creativity, honesty, liberalism, and other qualities is not supported by empirical data." And he went on: "There are no scientific studies which show that religion is capable of serving mental health" (Sanua, 1969, p. 1203; see also Bonelli & Koenig, 2013, p. 658). That was quite a statement in one of the leading psychiatry journals, the AJP.

Batson and Ventis (1982, pp. 211-251) commented on the findings of Sanua (and others). It is, as they write, as in the parable of the blind men describing an elephant (p. 232). Therefore, Sanua is wrong and right at the same time (p. 233). The reason for contradictory conclusions can be understood on basis of different conceptions the authors have of mental health and of different ways of being religious. That will prove to be a common thread in what follows (see also Dengah II, 2017; Pieper & Van Uden, 2005; Wulff, 1991).

Intermezzo I: Criticism and worry

Before discussing the next review, published in 1983, I draw attention to an important paper, published in 1986, in the same journal as Sanua's paper, in which the authors looked back on a period just before the publication of that next review. The article was a clear and, in a sense, alarming signal. The authors presented a systematic analysis of research on religious variables in four major psychiatric journals, including the AJP, in the period 1978-1982[2] (Larson, Pattison, Blazer, Omaran, & Kaplan, 1986). One could say that publication trends on religion in leading journals were at that time a kind of genre, which Larson and colleagues joined (Buehler, Hesser, & Weigert, 1970; Capps, Ransohoff, & Rambo, 1976). In any case the recipe was known.

2 The three other journals were: the *British Journal of Psychiatry*, the *Canadian Journal of Psychiatry*, and the *Archives of General Psychiatry*. The authors examined five issues: the frequency of inclusion of religious variables in quantitative research, the robustness of statistical analysis, the type of measure of religion, the conceptual basis for measurement of religion, and awareness of the scientific data base on religious research.

Larson and colleagues reviewed 2.348 psychiatric articles and were able to find 59 studies in which a religious variable was included. Without going into detail, at that time, religious variables were seldom used in research and religious research was seldom cited. The undeniable conclusion of the authors was that here appeared to be a lack of knowledge and skills required to evaluate religion.

The reason for this study was a major concern. It was well known that there was and still is a disparity of religious beliefs and spirituality between mental health professionals and the general public. It should not influence psychiatric practice, but it inevitably did, not only in referral behavior but also in treatment choice. That disparity also meant a different appreciation of the function of religion and spirituality between the professionals and the public. This raises two questions. How does this lack of inclusion of religious variables disrupt the (at that time forthcoming) evidence-based practice? Because if religious or spiritual variables are not included what would that mean for the usefulness of research outcomes in certain cases? Secondly, how will the dialogue on values and preferences with regard to treatment recommendations between mental health professional and patient proceed if there is such a difference in appreciation of the meaning of religion and spirituality? The risk of misunderstanding was and still is not imaginary. A potential conflict hung in the air. Unfortunately, another group of authors had to report in 1998 that there was no improvement (Weaver et al., 1998).

Bergin's 1983 review

Nevertheless, some change was announced with the publication of the second review, published in 1983, written by the then well-known psychotherapy researcher Allen Bergin (1983). He made it very clear that review of empirical data is not just an empirical matter! Other issues are involved. In the first place, values and ideology influence theoretical assumptions. For instance, what was true at that time and still is today is that the main assumptions of dominant theories are naturalistic and humanistic rather than theistic and spiritual. That means that it might happen, and it obviously did happen, that ideological choices were taken as facts, which they certainly are not. Another influential aspect was the already mentioned religious noninvolvement of mental

health professionals in contrast with the substantial involvement of the general population in religion and spirituality. A third influential aspect Bergin brought out was that because of these conceptual and attitudinal biases religion and spirituality were excluded from measurement or included in such a way as to confirm prejudices with regard to religion and mental health. These three issues still should be kept in mind when one studies empirical surveys on religion and mental health!

Bergin included 24 studies from 1951-1979; that covers more or less the period Sanua looked at, but they have only three references in common. Bergin also presented a quantitative sum of data, leading him to include only studies that had at least one religiosity measure and one clinical pathology measure. His findings set the trend for the years to come. On a total of 30 outcome measures only 7 (23%) showed a negative relationship between religion and health. A positive relationship was shown by 47%, and the remaining 30% showed a neutral relationship. Bergin showed himself a modest man, nevertheless. He cleverly stated that he had not found support for the assumed overall negative relationship between religion and mental health, but he admitted at the same time that he had only found marginal support for the positive effect of religion. Part of the problem lay in the limitations of measurement and methodology, which actually still are problematic issues, despite overall improvements. Another important improvement made by Bergin was his attempt to reckon with the fact that religion is a multidimensional concept, and that different aspects of religiosity are related to different aspects of mental health, and that therefore religiosity is not just a matter of healthy or unhealthy religiosity. In other words, measurement of religiosity is a complicated matter and requires careful attention. That will be the next step forward. However, since Bergin's publication the results of reviews have confirmed his outcome. There always appear to be mixed results, but the overall finding is a positive correlation between religion, spirituality and mental health (see also Shuman & Meador, 2003, pp. 22-24). By the way, it was not Bergin's first paper on religious values, psychotherapy and mental health, as it followed his much-publicized 1980 report (Bergin, 1980). His "coming out" about religious values hit the psychotherapeutic world with a bang. "A bombshell hit the world of empirical psychotherapy research in 1980 when Bergin argued that despite their reticence,

psychotherapists had a set of values about a good life which could be called "religious", and that such values correlated positively with mental health" (Holmes, 1999, p. 236; see also Richards, 2016).

Intermezzo II: DSM-IV

Meanwhile changes were coming on an entirely different front. In DSM-IV some major interventions were made with regard to religion and spirituality. The content of the DSM-IV glossary of technical terms had been rewritten in-depth. Larson and colleagues (1993) had found an overrepresentation of religion in the examples of psychopathology in the DSM-III-R glossary of technical terms examples.[3] They could not conclude otherwise than that the glossary showed a bias against religion and a remarkable insensitivity in interpreting religion. The new glossary was an improvement. Secondly, the chapter on cultural sensitivity was introduced, including five items: cultural identity, cultural explanations of the illness, cultural factors related to the environment and level of functioning, cultural elements of the relationship between the individual and the clinician, cultural assessment for diagnosis and care (American Psychiatric Association, 1994). It is obvious that religion and spirituality are integral parts of these five items. The third major change was that a code for Religious or Spiritual problem was introduced. That made it possible to take religious and spiritual problems into account and even made it possible to pay attention to these problems in diagnosis, if necessary. Let us conclude that DSM became less biased against, more sensitive to religion and spiritual issues; the changes were maintained in DSM-5™ (American Psychiatric Association, 2014; Lukoff et al., 2010; Peteet, Lu, & Narrow, 2011).

Meta-analysis: Hackney and Sanders' 2003 representative example

"Extensive research has been conducted and comprehensive data are available, but the relationship between religion, spirituality and mental health is still disputed. Indeed, there are some clear examples of a

3 See also Chapter 2, pp. 30-31.

negative effect of spirituality or religion on mental health. Nevertheless, a majority of experts seem to agree that in general the relationship [between religion, spirituality and mental health] can be qualified as positive" (Verhagen & Cook, 2010, p. 620). A preponderance of studies indicates that religious individuals fare better than their secular counterparts in psychological disorders.

Instead of summarizing studies it is interesting to look in some detail at one of the frequently cited meta-analyses, done by Hackney and Sanders (2003; see also Hackney, 2010). One of the main difficulties and an arena for disagreement is the fact that researchers deploy diverse definitions and scales of religion, spirituality and mental health. Religion, spirituality and mental health are multidimensional constructs and we still wrestle with a lack of (scholarly) consensus on how to define these constructs. The authors solved the problem in a rather elegant way. They looked at the way religion and mental health were defined in the studies they included (35 studies between 1990 and 2001) and developed a classification scheme along the following lines. Definitions found in these 35 studies that focused on the social and behavioral aspects of religion (e.g., attendance of services, participation in church activities) were coded as "institutional religion". Definitions that focused on beliefs involved in religious activity (e.g., ideology, attitudes, belief salience, and fundamentalism) were coded as "ideological religion". Definitions that focused on personal, internalized devotion (e.g., emotional attachment to God, devotional intensity) were coded as "personal devotion".

Hackney and Sanders also coded definitions of mental health or psychological adjustment. Definitions focusing on the unhappy aspects of mental health (e.g., depression, anxiety) were coded as "psychological distress". Definitions that focused on positive feelings regarding the self and one's life in general (e.g., self-esteem, happiness) were coded as "life satisfaction". Definitions of psychological adjustment focused on more growth oriented and humanistic aspects of mental health (e.g., identity integration, existential well-being) were coded as "self-actualization".

The authors found 264 effect sizes, only 78 of them were negative; most of them near zero or non-significant. The results showed that variation in definition or type of religiosity is one systematic source of variation in the effect sizes. The results also showed that the religiosity

main effect took the form of significant increases in mean effect size as one proceeds from institutional religiosity to ideology to personal devotion. Also the variation in definitions of mental health is a source of systematic variation. The main effect took the form of significant increases in mean effect size as one proceeds from definitions centered on low psychological distress to life satisfaction to self-actualization. The authors also focused on the issue of interaction between types of religiosity and types of mental health. For example, when religiosity is defined as personal devotion a very slight increase in mean effect size from lack of distress to life satisfaction is followed by a large increase as one proceeds to self-actualization.

To summarize, regardless of any consideration of religiosity or mental health definitions religiosity may be said to have a moderate positive overall, helpful, salutary relationship with mental health; a consistent finding over the years. Allen Bergin set the tone (1983). At the same time each position that has been taken in the debate is supported: positive relationships (between personal devotion and self-actualization), negative relationships (between institutional religion and psychological distress), and non-significant (between ideological religion and psychological distress).

Bonelli & Koenig's 2013 review

The fourth and most recent review I want to highlight was published in 2013, written by Bonelli, Sigmund Freud University in Vienna, Austria, and Koenig, at Duke University in, Durham, North Carolina in the USA (Bonelli & Koenig, 2006; Bonelli, 2014). They examined the period 1990-2010 and looked for original research in the top 25% of psychiatry and neurology journals according to the ISI (Institute for Scientific Information) journals citation index 2010. They found 43 studies that met these criteria. They also used criteria for rating the quality of each study, which is an important addition and improvement given the usual criticism on studies on religion and mental health. These criteria look at (a) study design, (b) sampling method, (c) number of measures, (d) quality of measures, (e) quality of mental health outcome measures, (f) contamination between outcome and religion/spirituality measures, (g) inclusion of control variables, (h) statistical method.

The results were sorted into six categories: (a) no association (NA), (b) at least one significant positive association and no significant negative associations (POS), (c) positive association, but significance level borderline, (d) at least one significant negative association with better mental health and no significant positive ones (NEG), (e) negative association, but significance level borderline, (f) mixed, that means both significant positive and negative associations (MIX).

They divided the results according to diagnostic groups following ICD-10 and concluded that 72.1% of the studies reported a positive relationship between religious involvement and better mental health. Of course one would like to know what is meant by "religious involvement". Although more than 40 different measures of religion/spirituality were used in these studies, all assessed the degree of involvement. That does not say too much compared to what was stated in the third review, but that is what Bonelli and Koenig have to say on this.

The summary of the results showed that 72.1% of the studies showed a trend toward positive association, 2.3% showed no association, and 18.6 % demonstrated mixed results, 5.7 % showed a negative association. One could also formulate that 93% (72.1% + 2.3% + 18.6%) found at least one positive association, whereas 23% (18.6% + 4.7%) reported at least one negative relationship. Regarding the diagnostics groups, all studies on dementia (2), suicide (3) and neurosis (3) found a positive association, 79% of the studies on depression (19) and 67% of those on substance abuse (9). Most findings in schizophrenia (5) were mixed or positive, in bipolar disorder (2) mixed or negative.

They also make an important statement on the quality aspects of these studies. According to their rating of the quality of studies before and after 2000 they found an improvement in quality of methodology and design.

The authors compared their results with two earlier reviews published in 1986 (Larson et al., 1986; discussed in *Intermezzo I*) and 1992 (Larson et al., 1992) in the AJP. Their review in fact serves as a follow-up of these two. The 1992 study paid special attention to aspects of religious involvement and found that dimensions such as ceremony, social support, prayer and relationship with God do have positive associations with mental health. However, at that time the authors were surprised by the fact that even when a religious variable was specified in the majority of the cases there were no reported efforts either to

formulate a hypothesis or to test the association between religious measures and mental health. In their case for only 22% of the measures a hypothesis was specified and of these 22% only 40% reported the results. Bonelli and Koenig conclude that their findings are similar to those reported by these earlier reviews, but that research has improved. That does not mean that there are no methodological issues left. To mention a few: Religion and spirituality are multidimensional constructs, and therefore it is necessary to specify which dimensions are assessed. Especially spirituality is a difficult concept if one wants to avoid an all too large similarity with religion or mental health. And what exactly is meant by non-religiousness, atheism or agnosticism? Another issue is the fact that most studies are cross-sectional, therefore giving no indication about causality. Religious factors may function in different ways across the life span. And one should realize that it is not always clear for what reason people are religiously involved, including reasons that have nothing to do with religious beliefs (e.g., "risk avoidance").

Evidence-based practice

We have no reason to doubt the results of these reviews. Given these outcomes, the next question is whether and how these findings become integrated in clinical practice. This brings us to the area of evidence-based practice. We already suggested some potential difficulties and we will now look for possible answers. However, these potential difficulties are real. We will first look at the evidence-based practice itself, and secondly we want to examine in what way the ethics of evidence-based medicine and psychiatry influence the concept of religion. Evidence-based medicine is about achieving health. However, does the concept health itself combine well with classical religious traditions or does it combine better with a new type of religiosity? And if so, what type?

In every guideline, handbook or recommendation on evidence-based practice one can find that at a certain moment the findings must be summarized, after examining the literature, and then value judgments or preferences should be applied (Guyatt, Sinclair, Cook, & Glasziou, 1999). For instance: "Having made estimates of the conse-

quences of alternative strategies, value judgments about the relative desirability or undesirability of possible outcomes becomes necessary to allow treatment recommendations. We will use the term *preferences* synonymously with *values* or *value judgments* in referring to the process of trading off positive and negative consequences of alternative management strategies." (Guyatt et al., 1999, p. 1837) The final step is, after all, how to apply the results to the patient. With ignoring all sorts of aspects of this final step, an important point is the demand for the values and expectations of the patient. Of course, this means values and expectations with regard to the treatment that is recommended and the prevention of unwanted outcomes. The idea that patient values are of great importance in clinical decision-making, is repeated time and again (Gupta, 2017, p. 119). At the same time it is not very clear how patients' values are integrated with research evidence and the clinical expertise of the professional. That is probably even more true for religious values. For instance, if religious or spiritual issues are important in any way, is the clinician prepared or willing to include a religious or spiritual aspect in the framing of the search question? And what has the patient to say to that? In other words who is the owner of the critical appraisal? Then, as Gupta (2017) makes explicit: "What version of health is valued by the methods used and the outcomes measured?" (p. 120) This is really an extremely important question and illustrates very clearly that values are implicitly or explicitly present from the very first step of the evidence-based recommendations process. We must ask, is religion or spirituality or meaning-making seen as integral part of (mental) health, on what grounds? And if not, on what grounds is it rejected?

This is one part of the problematic use of evidence-based medicine in psychiatry and religion and spirituality. There is another issue to ask questions about. Obviously the researchers in the field of religion and psychiatry intend to create greater awareness of the meaning of religion and spirituality in psychiatry and psychotherapy. And they tried to achieve this by conducting their research in accordance with current quality requirements. As we have seen, they have been quite successful in achieving this goal. But why? Is this goal worth achieving? To answer these questions it is useful to look at the ethical basis of evidence-based medicine (Gupta, 2017, pp. 117-148). According to Gupta's analysis of the ethics reflected in evidence-based practice we ought to pursue

evidence-based medicine because that is the only way to pursue the most effective means of achieving health. Health is the central value and the justification for applying evidence-based medicine. Gupta convincingly explains that this approach means a consequentialist point of view. What counts is the actual consequence of an act. By that one can determine whether an act is morally right or not. There must be a consequence that is good in itself: achieving, improving health is such a consequence. This type of ethical reasoning belongs to the school of utilitarianism. The slogan for utilitarianism is: "The greatest good of the greatest number" (Fulford, Thornton, & Graham, 2006, p. 514).

The immediate question is does religion fit in such an approach? Is religion in that sense a (useful) element of the "most effective means of achieving health"? That is a difficult question, which cannot be answered directly. Shuman and Meador (2003) wrote:

> Yet it is difficult to say whether or to what extent medicine's emergent alliance with religion is really good news for people of faith. Given the highly individualized character of religious belief in contemporary American culture, the religion that medicine has (re)discovered may be no more than a simulacrum of any one of those several ancient, historical traditions we typically think of as religions. While this point probably does not make much difference to those whose overarching concern is the physical well-being of the individual and the way religion can contribute positively to that health or to those concerned with meeting the needs of the medical consumer, it does matter theologically – at least to those of us who believe that theology has something to say about the way things really are. (p. 20)

This lengthy quotation draws on several discussion points. Most importantly, the authors draw our attention to a difference between religion and religious traditions. Religious traditions are about living and dying faithfully. Religion in its alliance with medicine is about living healthily. Living and dying faithfully is living and dying in fruitful relationships with the deity, oneself and other people, and the world around, "whether in sickness or in health" (Shuman & Meador, 2003, p. 21). So what kind of religion are we talking about? In fact, although participants in empirical studies belong to religious traditions, religion is

understood in a more generic way. What does that mean? Shuman & Meador refer to the analysis by the theologian Lindbeck (2009). He explains that in modern times the propositional understanding of religion has lost its popularity and that what he calls an experiential-expressive understanding of religion is in the ascendency (Lindbeck, 2009, p. 5). "Experiential-expressive" means a focus on the experience of the religious person. Doctrines function as nondiscursive symbols of inner feelings, attitudes and existential orientations (Lindbeck, 2009, pp. 2-3). It is my opinion that this individualized type of religion exactly fits within the cultural values of the modern world.

Cultural values: Two dimensions[4]

The values surveys of the European and World Values Studies (EVS/WVS) are the largest investigations of attitudes, values and beliefs around the world and are designed to provide a comprehensive measurement of all major areas of human concern, including religion. The data show that on the one hand economic development is associated with a shift away from traditional values. Based on the work of Inglehart it is shown that the differences between advanced societies and low-income societies across a wide range of values can be plotted along two dimensions: traditional versus secular-rational values and survival versus self-expression values (Inglehart & Baker, 2000; Inglehart & Wezel, 2010). According to the view of the authors on modernization the traditional versus secular-rational dimension reflects

4 I previously addressed the importance and usefulness of the cultural values maps in the analysis in Chapter 4, for which I used the World Values Survey (WVS) wave 5. WVS wave 6 is now available (2010-2014), and wave 7 is in preparation. Subsequent waves are planned every five years. (Retrieved from http://www.worldvaluessurvey.org/WVSContents.jsp)
In this paper I added a new element to that analysis, to underline the importance of the values maps, especially with regard to the trans-cultural differences and the consequences of these differences for psychiatric practice. Religion within advanced societies (secular-rational, self-expression values) functions differently than within low-income societies (traditional, survival values) (Dülmer, Inglehart, & Welzel, 2015; Krause, 2012).

changes linked with the transition from an agrarian to an industrial society, associated with rationalization and secularization. The second dimension is linked with the level of existential security and linked with the transition from industrial to post-industrial or knowledge societies. When survival is less secure survival strategies are more in the foreground. When survival can be taken for granted other goals and values become important.

The traditional versus secular-rational values dimension reflects the contrast between societies in which religion is important and those in which it is not. In traditional societies God and religion (belief in heaven and in hell) are very important along with work, children must learn obedience and religious faith, absolute standards are emphasized (abortion, suicide, euthanasia, divorce are never justifiable) along with respect for authority and national pride. And people describe themselves as "religious persons". Secular-rational values emphasize the opposite. The second dimension reflects the polarization between survival and self-expression values. Survival values are characterized by priority to economic and physical security over self-expression and quality-of-life. People who live survival oriented reject foreigners, and homosexuals. Hard work is one of the most important things to teach children, rather than imagination, tolerance and respect for others are not the most important things to teach children. And again, self-expression values emphasize the opposite.

Inglehart and Baker (2000) found evidence that orientations have shifted from traditional toward secular-rational values in almost all industrial societies. And when a society starts to become a knowledge society a new shift appears, from survival to self-expression values. Self-expression tends to interpersonal trust, tolerance, subjective well-being, quality of life and self-expression. That focus on self-expression is what we immediately recognize in the analysis of the kind of religion we are looking for. That type of religion fits perfectly into this cultural profile. In that sense the alliance between medicine and religion, and that between psychiatry and religion, are accompanied by a culturally modern understanding of religion, at least in the western world. We recognize it especially in the approach of the third review (Hackney & Sanders, 2003).

How to proceed? Uncertainties and scenarios!

In this final paragraph I will give a preliminary sketch of a prediction based on the literature by identifying certainties and uncertainties and their impact with regard to the research on religion and spirituality and (mental) health (Figure 1; Dein, 2014; Dein, Cook, & Koenig, 2012; Dengah II, 2017; Hackney, 2010; Hill & Pargament, 2003; Koenig et al., 2012). Secondly, I will formulate possible scenarios and desired developments (Figure 2).

In what follows I use the so-called scenario method (Bierbooms, Bongers, & Van Oers, 2011; Vollmar, Ostermann, & Redaèlli, 2015). This method has been developed for strategic planning. Strategic planning could be very useful to help advance the research field and clinical practice of religion and spirituality in psychiatry. First we must have a picture of the developments in the field, then we have to decide which of these developments are certain and which are uncertain. The next step is to choose two key uncertainties based on their level of uncertainty and their impact in the field. Of course in a regular procedure of the scenario method inventory making and decision making is based on analysis of research and documents and on interviews with experts and stakeholders. In my proposal the material I have presented in this paper is primary.

Figure 1 shows two axes and four quadrants. In the left upper quadrant the advances are plotted. However, their impact in research and clinical practice is still low. In the left lower quadrant I plotted the problematic issues that still surround the field of inquiry and that contribute to high uncertainty, but still have low impact. On the right upper side we see that professional development and policy-making certainly make a difference because of their high impact. In the right lower quadrant we see the most problematic fourth part. Unawareness and lack of consensus in professional documents and scientific journals will continue to have high impact and great uncertainty in the field will be maintained.

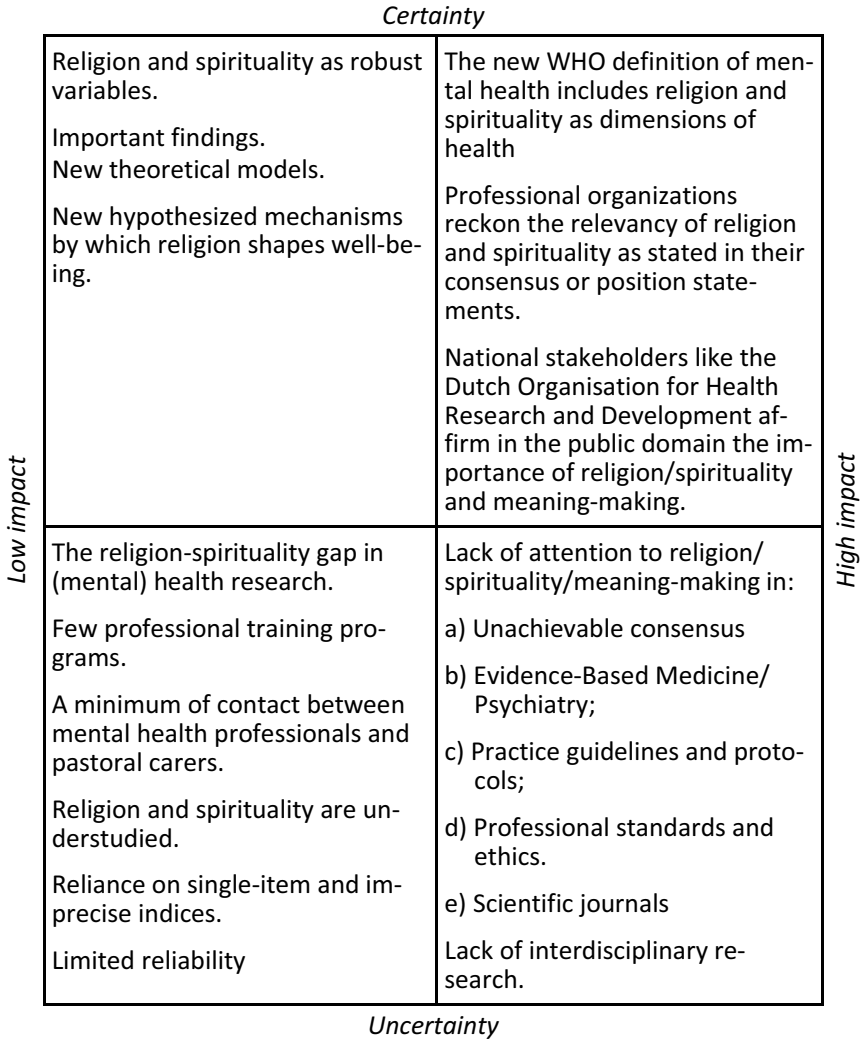

Figure 1. Identification of uncertainties with regard to the impact of research on religion/spirituality on psychiatry and mental health care.

In line with the reasoning in this contribution two key uncertainties can be identified: attention to religion and spirituality by evidence-based medicine/psychiatry and consensus on religion and spirituality in psychiatry (Figure 2).

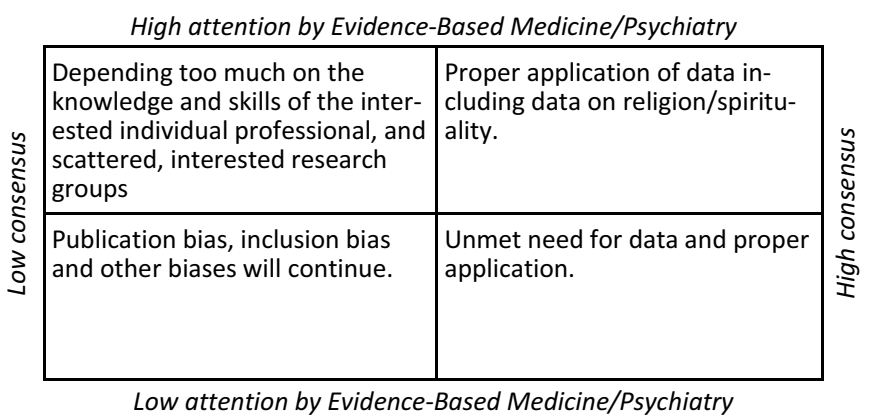

Figure 2. Scenarios for the impact of research on religion/spirituality on psychiatry and mental health care.

If consensus is unachievable then attention to religion and spirituality in psychiatry will remain dependent on the interest of individual professionals and a few interested research groups. If consensus remains unachievable and interest is low then all sorts of biases will continue to play their disturbing role at the expense of good research, and in the end at the expense of the welfare of the patient. On the other hand, in case of high consensus and high attention the application of data in clinical practice will include values and preferences, including which religion and spirituality. In case evidence-based medicine/psychiatry falls short in attention to religion and spirituality in psychiatry despite consensus unmet need for data and their proper application will remain.

Conclusion

The first aim of the historical overview was to show that empirical research improved over the years, and research syntheses improved as well. There is good evidence that religious involvement is correlated with mental health in three major domains of psychiatry: depressions, substance abuse and suicide. There is some evidence for two other domains: stress related disorders and organic mental disorder. There is insufficient evidence for bipolar disorder and schizophrenia, and no

evidence for a lot of other disorders, which of course means that more research is needed. Most important is the finding that at least in the last 20 years, but even longer, the findings are fairly consistent. The majority of studies do show positive associations between religious involvement and mental health. However, one should not close one's eyes to the fact that also mixed and negative results also reappear every time.

The second aim was to show that within the context of evidence-based medicine the pursuit of health has consequences, perhaps unexpected, for our understanding of religion in contrast with what we call the classical religious traditions. The general matter of ethics with regard to evidence-based psychiatry turned out to be important for the evaluation of evidence on religion and spirituality in psychiatry. What kind of religion are we talking about within this perspective of evidence? A critical theological evaluation and the use of the European and World Values Studies helped us to find an explanation.

Finally, based on our findings and discussions we were able to sketch four scenarios with regard to the impact of research on religion and spirituality on psychiatry and mental health care. Our most important conclusion is that we have to work towards an ethical consensus.

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Part II. Consensus

Part two is dedicated to the search for consensus. Chapter 6 brings together four pieces of work. The last one, 6.4, is the actual text of the Position Statement as it was accepted by the Executive Committee of WPA. It is preceded by a text, 6.3, in which I called for the WPA leadership to take the lead in the process searching for a consensus. In 6.1 and 6.2 I reflect on the debate on religion and science. In particular, the approaches of Barbour and Drees get full attention. My aim was, and is, to find a means to escape from an unfruitful battle and division. If that was not possible, a consensus would remain far out of sight. Two statements were primary: WPA should reconsider its position on religion in psychiatry, and religion and psychiatry should no longer be seen as enemies but as allies against superstition and nonsense, respectively.

Chapter 7 has the title "Consensus reached!" I used the exclamation mark to give extra emphasis. In my view it is an achievement, but not without some risks, as I mentioned at the end of Chapter 5. If awareness of the meaning of religion in psychiatry remains low and consensus among psychiatrists remains unachievable, then the Position Statement will only remain only paper.

Chapter 8 goes a step further and is an attempt to connect metaphorical thinking with science-based language from DSM-5™. After all, that is the challenge for dialogue and collaboration: how to connect, how to evaluate the interaction between religious metaphorical language and science based concepts?

What do we mean by consensus? Consensus in science is achieved through various means of communication: at conferences, publication of research, replication of research and the instrument of peer review. A consensus is therefore a collective agreement or opinion among scientists, not necessarily unanimous, based on dialogue and accord, not on authority or dominance. Consensus is the result of deliberation

based on critical reflection. The participants in this deliberation recognize the outcome with a positive attitude. The consensus on religion in psychiatry respects religious truth claims but does not admit them as a basis on which decisions are taken.

Chapter 6

Towards a position statement

6.1 Psychiatry and religion: World Psychiatric Association beyond boundaries[1]

Introduction: Central themes listed

There is a lot to tell and to explain with regard to the interface between psychiatry and religious experience. In light of recent publications and reviews of empirical findings it is a good moment to discuss the central themes at more length and in more depth. A long list of these central themes could be enumerated. To give a specimen of such an overview: in a World Psychiatric Association (WPA) volume on Religion and Psychiatry the editors distinguished seven fields of interest (Verhagen, 2010b).[2] First of all, in response to a question such as "Where to

1 Published as: Peter J. Verhagen, *Actas Españolas De Psiquiatría*, 2012 [Special Issue]*, 40*, 60-65, Supplement 2.

2 For this subdivision I used the idea of a theological discipline which is called "the encyclopedia of theology". A more modern term for this is "the architecture of theology". The discipline of the encyclopedia or architecture of theology, or any other discipline, aims at the scientific research underlying the internal and external coherence of theology or any other science, in itself and in relation to the academic world. It is about "solidity, organization, and structure" (McGrath, 1994, p. 119). McGrath's characterization of theology also applies in a sense to the current topic: "For theology is a complex discipline, bringing together a number of related fields in an uneasy alliance" (McGrath, 1994, p. 119). A similar characterization applies to the relationship between psychiatry and religion. *Continued next page>>*

begin?", they started with so-called Prolegomena: history, philosophy, science and culture. This opening intends to draw the readers' attention and stimulate reflection on core historical and philosophical considerations when contemplating religion and mental health. It seems as if psychiatry still has to start (over again) with the historical and philosophical problems at the interface between psychiatry and religion.

Secondly, since about 80% of the world population embrace one of the known religious traditions and approximately 4,200 different religious/spiritual groups are known, psychiatrists inevitably are required to know about core issues of various world religions within the social and cultural context of their clinical practice. The necessary information on religious traditions circles around a central figure (or figures), a central message and central structural elements. From there it is illuminating to look at ideas, concepts, popular beliefs and religious practices regarding health and mental illness.

Psychopathology is the core business of psychiatry. So, thirdly, a lot must be explained about religious psychopathology. Contributors to

> This relationship manifests a complex interwovenness and brings together many related disciplines in a tense field. This is precisely because the alliance between psychiatry and religion was uneasy from the very beginning. What do we want to achieve then? It is not enough to say that a topic is interesting, worthwhile, promising or rich, or that it is nonsense, esoteric, useless or poor. It is necessary to state that this bringing together requires a certain consistency and coherence. Otherwise we would only have a list of isolated parts. A point of view, whether it is a view of life (religious or otherwise) or a scientific discipline, should have an internal and external consistency and coherence. Internal and external consistency means that the point of view is without contradictions. A criterion for internal coherence is the need for the elements of a point of view to fit together "to a degree that is sufficient to ensure that the point of view as a whole forms a unity" (Markus, 2004, p. 153). If the elements contradict each other, there is no consistency and the point of view is fragile. External coherence and consistency mean that the point of view one assumes is coherent and does not contradiction one's other views about the same issue of reality (Markus, 2004, p. 154). In fact, although the criteria of consistency and coherence are derived from philosophical theology with regard to views of life (religious or otherwise), they are useful and accessible in every scientific discipline (Stenmark, 2012).

the volume cited discuss not only religious experience and psychopathology, normal and abnormal religiosity, psychosis and depression and obsessive compulsive disorder are discussed, but also religion from a psychoanalytic perspective, and religious fundamentalism. On the one hand, conceptual elimination of religious and spiritual aspects may ultimately lead to psychiatrists losing their patients. On the other hand, religious and spiritual issues and their dynamics are interwoven with the process of symptom formation.

To these three main issues several others could be added. Recent neuroscientific developments have broken down the dualistic barrier between observation and behavior and the activation of brain structures. There is no mental function that is not orchestrated by processes activated in the brain. And mind still matters. The challenge is to explain why, and to do so not in opposition to neuroscience. In the meantime research and empirical studies are necessary in order to clarify the possible relations between religion and mental health; religion can be harmful, religion can be helpful and a generally positive force. A great deal must still be achieved. In evaluating empirical data one always needs to keep in mind that researchers' choice of this or that indicator of religiosity and measure of a (specific form of) psychological disturbance is guided by more or less explicit ideas about what religion and mental health are. This list is not complete without mentioning the interdisciplinary and training issues. Multidisciplinary teams are commonplace in mental health institutions. Psychotherapy, pastoral care and spiritual care and meaning-making contribute to the care of psychiatric patients. Their discipline-specific assessments have a lot to add to our understanding of the patient concerning diagnosis and treatment interventions. Psychiatric residency training, continuous medical education and psychotherapy training lay the foundation of acquisition and improvement of knowledge, skills and attitude. The very same holds true for religion, spirituality, worldview and the interface between psychiatry and (the study) of religion.[3]

3 We also published the first "proposal for a WPA consensus or position statement on spirituality and religion in psychiatry" (Verhagen, Cook, 2010, pp. 630-631). At the end of this Section (pp. 133-134), the draft is included as it was accepted by the Section and the Executive Committee of the Spirituality Special Interest Group of the Royal College in August 2008.

"Deadly dance"?

Although it is not really difficult to imagine that these "central themes", as I called them, have (or perhaps used to have) something to do with each other, it is not clear at first glance how and even why they interconnect. It is here that we enter the intriguing field of thinking and discussion of science (psychiatry) and religion. Science and religion have often been seen as enemies locked in mortal combat; an unnecessary and in fact unacceptable stance. The start of psychiatry is in fact an illustration of this development in which religion lost its leading position and the physician became the new guide in life with scientific and moral authority. Since then the relationship between psychiatry and religion has been strained to a greater or lesser extent.

We are used to Barbour's (2000) fourfold typology as the standard manner to present the relationship between science and religion. He proposed a description of the field of "science and religion" using four categories: conflict, independence, dialogue and integration. However, one could elaborate on this scheme and argue that on the social level of science (psychiatry) and religion these four types of relations correspond to four types of attitudes health care professionals may take towards their own religious involvement and towards their religiously or spiritually involved patients. (I will return to Barbour's typology later on.) The Swedish professor of philosophy Stenmark (2004) formulated a threefold typology: (a) no overlap between science and religion (independence view), (b) overlap between science and religion (contact view), (c) union of the domains of science and religion (a monist view). Barbour's dialogue and integration are two versions of the second type according to Stenmark. In his model he emphasizes that it is important to pay attention to the aspects where science and religion might be related. He takes into account four dimensions: the social structure of science and religion, the aims of these practices, the kind of epistemology they exhibit and the theoretical content. This approach helps us to achieve a more differentiated picture of the interactions between science and religion. What would be for instance the overlap, if there is any, and the difference between psychiatry and religion in a teleological sense? If it would be appropriate to say that both practices aim at "healing" or at helping relationships, there would still be a great difference between mental health and welfare (salvation) as a goal and in

healing methods despite the fact that the relationship between "the healer" and "the healed" is fundamental for employing the method in both practices (Verhagen, 2010b, p. 9).

Two statements

The "locked position" is clearly not fruitful and should be changed for several reasons. Obviously, the boundary between religion and spirituality and the practice of psychiatry is becoming increasingly porous and this requires from psychiatrists to be more knowledgeable. Another important development is that, although spirituality is not mentioned as an aspect of the definition of health, the World Health Organization (WHO) has rightly regarded religious, spiritual and personal beliefs as a component of quality of life. Thirdly, the growing awareness after nearly a century of neglect may necessarily enhance the study of religion and spirituality in psychiatric training, research and practice. Organizations such as the WPA should take the lead. Therefore, I would like to formulate two statements:

1. The WPA, which represents world psychiatry, must change its position toward religion and spirituality. It should do so by crossing narrow-minded scientific boundaries such as reductionist and materialistic boundaries.
2. Psychiatry and religion should not be regarded as opposing adversaries against each other, but as allies against nonsense and superstition.

First statement

I ask WPA to take another position, a new position with regard to religion and spirituality. Another position demands for another vision! Our work requires a new, a better view on "science and religion". No doubt WPA has a vision on science and psychiatry. However, it could be argued that this vision on science is a one-sided view on human nature, the world and on religion. One-sided because it is dominated by gathering evidence, mathematical modeling, systematic empirical testing, with the goal of providing the fullest and most reliable explanations for everything that occurs in the natural world (Cottingham, 2005). One-sided, in meta-theoretical terms, because of its really understandable

ideal of a detached, external position in order to achieve objective knowledge. (Cleary religious understanding cannot be achieved from such a position.)

In the meantime science does play a role in the way we live and the way we perform our professional duties, whether religiously or non-religiously. Religion does play a role in the way we look at, make use of and live with science. And both religion and science are about the truth of ideas, and about the acceptance of religion in a science-minded culture and about the acceptance of science in a religiously minded context.

Before proceeding I should explain that for the sake of the argument I will take an outsider perspective on religion. In other words, I will not argue from a religious point of view. The insider perspective would be based on particular creeds, revelations or experiences. If I were to do that I would immediately cause a lot of trouble, because it would seem as if I had chosen in favor of a certain religious tradition and against other traditions. I would immediately lose my case, because WPA would never, and justly so, take such a position; that would be disastrous! In fact, the danger of such a partiality has crippled WPA (and WHO) in developing a view on religion and health. My position in this paper is the one of the outsider and observer. I am arguing not about the truth of religion, but about the best available truth about religions. Religion and science, as a theme, speaks of that which we value, that which we hold to be true, and that which we hold to be possible. And with this outsider perspective on religion, human nature and the world I bring a vision that reflects upon its own possible meaningfulness, truth and value (Drees, 2010).

What kind of vision is required? I will follow the analysis and the model developed by the Dutch professor in philosophy of religion and ethics, Willem Drees (2010) in his *Religion and Science in Context. A Guide to the Debates*. Examining religious views, it is reasonable to say that religions can be defined as systems of symbols, and that symbols bring together, so to say, people's ethos and their world view (according to Geertz, 2008). Symbols bring together the appreciation of reality and the norms for our behavior. So it would be reasonable for me to argue that a world view, religious but also non-religious I would say, has a descriptive and a prescriptive aspect. For instance, speaking of the

world as God's creation has a descriptive and a prescriptive aspect to it. Take for example the Christian doctrine of humanity being made in God's image. Humans are thus seen as created, with a special position as the height of God's creation. This leads to the idea of human stewardship of creation in contrast with an idea such as human ownership of the world. A worldview, religious and non-religious, offers a view of "the way the world is and should be, of the true and the good, of the real and the ideal" (Drees, 2010, p. 76). In other words, the vision we require offers a particular cosmology – as a view of the way reality is – and an axiology – a view of the values that should be realized. The same example: to speak of the world as God's creation is a cosmological claim, and therefore that we must be good stewards is a normative claim.

So what we have now is a religious or non-religious vision that in a certain way holds together two dimensions. It is important to draw attention to two parts of this way of phrasing. It is essential to notice the aspect of "holding together". In "religion and science" it is of course important to analyze the cosmological aspects; that is the contribution science makes to our worldview. However, it is also necessary to be aware of where other judgments come into play; judgments not based on science but on moral, aesthetic or religious preferences. Otherwise we would move from factual to normative claims without recognizing the transition. In the second place, it is exactly this "in a certain way" that offers a lot of openings for further exploration and reflection, especially in such a diverse multi-religious, multicultural organization such as WPA. For instance, we speak of religious or non-religious visions, by which we do not imply that this or that non-theist's non-religious view is deficient in understanding, nor that a theist's view is deficient, but simply that they hold different existential positions in the way they hold together these two dimensions. The same holds true for different theistic or non-theistic religious positions. Another opening would be this more specific one, that the certain way in which the cosmological and axiological dimensions are held together allows for prioritizing. We are allowed to concentrate on existential issues which become prominent when our reality is not in accord with what we think ought to be (Drees, 2010, p. 77; Rashed, 2010b). This is certainly a typical experience of psychiatric patients confronted with the burden of mental illness! And still it is hard to recognize the existential dimension

in patients' stories. It appears to be much easier to pay attention to the facts than to the "whys" and "wherefores". The question is, however, whether that really is proper prioritization, although we do not want to minimize anything that is known about the diagnosis and treatment of that illness. On the other hand, it would also be conceivable that the patient makes a cosmological claim with regard to the origin of her or his illness, for instance possession by a demon. The professional cannot ignore this by just pathologizing such a claim.

I followed the line of reasoning by Drees and I will summarize our findings. We challenged WPA to develop a new position toward religion and psychiatry. We started looking for an appropriate view on "religion and science". And what we have found is a religious or non-religious view from which we distinguished but intentionally not separated two aspects: the cosmology and the axiology. Cosmology is related to science, is related to underlying experiments and observations, and is related to the world and daily life. Axiology is related to ethics, to underlying moral intuitions, and to the world and daily life. Drees (2010) presented an oval figure: at the top "a (non) religious vision", at the bottom "world & life", at the left hand side the line along "cosmology" as designated, at the right hand side the line along "axiology" (p. 80). I would like to challenge WPA to start working on a vision like the one presented; in my view it is a far more promising model compared to what has been done, or actually has not been done, with regard to psychiatry and religion.

Second statement

I assume that members of WPA are more or less acquainted with Barbour's (2000) view on religion and science, as I mentioned before. Barbour describes the field of science and religion with the help of four categories, or rather four relationships: conflict, independence, dialogue and integration. In general one might expect, given what is said about the (lack of) religious or spiritual commitment among mental health professionals, that the adherents of the first and/or second category will outnumber the other two (or three).

What to think of the following anecdote? In 2006 two Dutch psychiatric residents and their residency training director reported on a small qualitative research study of 13 psychiatrists currently working in a mental health service. The psychiatrists were each interviewed

about their attitude towards religious belief and spirituality. The interviewers were particularly interested in the possible role religion played in the relationship between psychiatrists and their patients. Reporting on countertransference issues, the Dutch interviewers quoted a typical statement from one of the psychiatrists' interviews: "If one learns that a patient is a believer, that patient's estimated IQ will actually be rated 20 IQ points lower". About half of the 13 psychiatrists interviewed attributed similar negative qualities to the religious patient (Fiselier, Van der Waal, & Spijker, 2006, p. 384).

Barbour's first relationship might in a sense be the most problematic one because of the forced choice it seems to entail. Therefore the second one might conceal in a sense what is going on. Anyhow, the second one and the other two more or less give the impression to mitigate the tension that is inevitably implied in the first one, as Drees noticed (2010, p. 5). In fact those who happen to be religiously or spiritually involved probably opt for a more friendly separation and division of labor (second relationship), a modified science (third relationship) or a more far-reaching integration (fourth relationship). Drees calls these three options the "ecumenical gathering" in religion and science (Drees, 2010, p.5).

For a community such as WPA there is a great risk in this. Such an ecumenical gathering could be in danger of excluding opponents of religion just as they would exclude opponents of modern science. Drees (2010) argues that an element of apologetics is involved here. Apologetics means justifying a particular belief or practice to others. In the religion and science debate we see two fronts. On the one hand, religion is defended in a secular scientific environment. On the other hand, science is defended among those who are worried about threatening scientific insights such as evolution (Drees, 2010, p. 11). In our handbook we tried to avoid such an apologetic stance (Verhagen, 2010b, p. 2). In fact we just did what Drees was pointing at. In the foreword a mild independence relationship seems to be observed in the field of psychiatry, and is cautiously called into question (Verhagen et al., p. xiv). In the preface the underlying tone is direct: "That psychiatry in the twentieth century was largely a *'Godless' period* was not to the advantage of the psychiatric patient. Religiosity can be considered a *normal* personality trait and cannot be disregarded by psychiatrists, whatever their own ideas on religiosity might be". (italics added; Verhagen et al., 2010, p.

xvii) However, as soon as one starts to discuss such core constructs as disease, mental health, religiousness and spirituality all kinds of background issues, assumptions, convictions, and mindsets come about. We are quite sure that psychiatry is not helped forward by any form of religious apologetics or expansionism; the model sketched in the first part of this contribution should help us to be aware of the many pitfalls.

Another risk is that an ecumenical gathering as depicted places us in a defensive position. The strategy would be something such as making a stand against the secularizing impact of science. Although we want to make a positive case for more effective relationships between psychiatry, religion and spirituality (Verhagen, 2010a), the risk is an agenda to counteract the advance of that science that seems to make religion mistaken or irrelevant. In the meantime, we do not seem to be very successful, in fact nothing seems to stop the advance of science, certainly not religion.

The innovative and intriguing position Drees (2010) takes is taken up in my second statement. There is another thinkable reason for engaging in the "religion and science". Our concern does not need to be "the future of religion but should be the persistence of superstition and nonsense" (p. 5). If that would be our joint concern the agenda and partnership in religion and science, in religion and psychiatry would be completely different. Challenging superstition and nonsense would be very satisfactory not only intellectually and religiously, but also socially and morally. Psychiatrists are all familiar with cases in which the patient is told by his spiritual healer that positive thinking in a spiritual or religious way will be healing. Let that pass. In fact there is enough empirical evidence supporting the idea that religiosity might have a supportive and/or protective effect (Sims, 2009). That many psychiatrists around the world are not aware of these facts is less appealing. But when the patient does not become well she or he might unnecessarily receive the burden of failing spiritually. Challenging superstition and addressing the nonsense in our field cannot be successful from the defensive position I pictured.

This challenge calls for a new dialogue, an interreligious and interspiritual dialogue, even a new kind of spirituality (Schmidt-Leukel,

2004).[4] If we develop our view along this line of thinking we must attempt as well as we can to differentiate between genuine spirituality and superstition, between science and pseudoscience. In other words, we need quality in our reflections on religion and science (Drees, 2010, pp. 39-40). I believe that will be the most important challenge to WPA. Searching for quality criteria, Drees formulates ten criteria paraphrasing the ten commandments (Drees, 2010, pp. 47-62). Paraphrasing the second commandment he writes: In religion and science we should not make carved images, in other words, we should not adore simple solutions. That is to say: "Avoiding ambiguity or indeterminacy might be helpful and clear things up, but resolving ambiguities by throwing out nuances and meanings is not helpful at all in exploring reality" (p. 53).

There are no universally accepted criteria for quality of religion nor for genuineness of spirituality. Psychiatry tries to manage with only two criteria: level of functioning, and cultural congruence (Rashed, 2010a). There also are no such criteria with regard to science (Drees, 2010, pp. 39-40; Van Holten, 2003, pp. 71-73). That would be our next challenge: working on quality in our reflections on religion and psychiatry.

Conclusion

I would like to conclude with an fine example by John Cottingham, that illustrates the holding together of a cosmological claim and an axiological one. According to Cottingham (2005, p. 19) we could argue that a scientific hypothesis may reasonably be adopted if it provides the most comprehensive and plausible account available of a given range of observable data. It is taken for granted that science has the capacity to explain. That has not always been the case. According to another position science was confined to description and prediction. However, there is no normative model of explanation in terms of one set of essential conditions for explanation, we have to work with "a plurality of models" (Van Holten, 2003, pp. 71-73). On the other hand, religious

4 Schmidt-Leukel (2004) outlined a new interfaith spirituality based on seven virtues: confidence, humility, curiosity, friendship, honesty, courage and gratefulness; see also his (2017) *God beyond boundaries*.

claims about the world or the cosmos are not explanatory hypotheses such as scientific explanations. Religious claims must be consistent narratives (consistency is one of the criteria for assessing religious or non-religious views of life; Markus, 2004). For instance a consistent narrative with regard to vulnerability and suffering, such as the following by Cottingham (2005): (a) "God's creation is necessarily imperfect", since logically it needs to be less perfect than God himself. Otherwise it would be like God instead of being created. (b) "God's creation, given his infinitely outgoing nature and creativity, will include a material universe", the material cosmos we are living in. (c) "Matter by its nature [as a series of unimaginable fleeting energy-interchanges] involves constant entropic decay." (d) "We human beings are formed out of matter." Reflection on (c) and (d) shows that creatures formed out of the dust will necessarily be mortal, which also means that the human condition is inherently vulnerable, and always subject to (the possibility of) suffering. The conclusion based on a narrative like this is that vulnerability, mortality and suffering are "(…) not just compatible with standard theistic principles regarding a perfect creator, but actually derivable from those principles" (pp. 28-29).

As I said, a religiously committed narrative such as this holds together both an exposition and interpretation by faith or religious conviction and explanation by science. Cottingham certainly helps us in adding quality to our reflections on science and religion.

Appendix to Section 6.1: Proposal

Revised proposal for a WPA consensus statement on spirituality and religion in psychiatry
(drafted by C.C.H. Cook)

Whereas spirituality and religion have often been neglected in clinical and academic psychiatry, they are increasingly recognised as being of importance in the understanding of psychiatric disorders, and in the clinical assessment and treatment of patients. Both terms lack a universally agreed definition.

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.

Religion is usually defined more in terms of systems of beliefs and practices related to the sacred or divine, and definitions often refer to social institutions and communities within which such systems are agreed and held in common. However, the scope and variability of such definitions is enormous, with some people identifying spirituality and religion as virtually synonymous, or at least as overlapping concepts, whilst others see them as contrasting or opposed categories. Others would see religion as much more individual than social, and yet others would focus less on religion as being concerned with belief systems and more on its concerns with morality, praxis or faith.

In many western countries, both religion and spirituality are now often faced with the context of a secular society, in which most public discourse is conducted without reference to either religion or spirituality. In many other parts of the world religious tradition continues to provide a shared frame of reference for public life and discourse. Faith communities, and spiritual or religious practices, have the potential to influence the course of mental illness, and attitudes towards people suffering from mental illness, for good or ill.

Whatever disagreements there might be on definition, spirituality and religion are concerned with the core beliefs, values and experiences of human beings. A consideration of their relevance to the origins, understanding and treatment of

psychiatric disorders should therefore be a central part of clinical and academic psychiatry. Spiritual and religious considerations also have important ethical implications for the clinical practice of psychiatry. In particular, it is affirmed here that:

1. *Spiritual well-being is an important aspect of health;*
2. *Empirical evidence reveals a largely positive relationship between religiosity/spirituality and different indices of health. However, religious and spiritual beliefs are powerful forces and may impart harmful as well as beneficial effects;*
3. *A tactful consideration of patients' religious beliefs and spirituality should be considered as an essential component of psychiatric history taking;*
4. *An understanding of religion and spirituality and their relationship to the diagnosis, aetiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development;*
5. *There is a need for more research on both religion and spirituality in psychiatry;*
6. *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, and not to use their professional position for proselytising or undermining faith;*
7. *Psychiatrists, whatever their personal beliefs, should be willing to work with leaders/members of faith communities, chaplains and pastoral workers in support of the well-being of their patients, and should encourage all colleagues in mental health work to do likewise;*
8. *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;*
9. *Psychiatrists should, whenever appropriate, work for a better understanding between colleagues and patients of different religions and cultures, bearing in mind that social harmony contributes to mental health and well-being.*

World Psychiatric Association Section on Religion, Spirituality and Psychiatry

Executive Committee of the Spirituality Interest Group (SIG), Royal College of Psychiatrists
11 August 2008

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6.2 Controversy or consensus? Recommendations for psychiatrists on psychiatry, religion and spirituality[5]

Introduction

A special issue such as the one at hand clearly demonstrates a broad collaboration among clinicians from very different cultural and religious backgrounds. Different continents are represented and the contexts within which "psychiatry and religion" is discussed are manifold. It appears to be possible to join efforts and to bring together clinical experience and research data in a thoughtful way. And fortunately a growing number of examples of these kinds of publications could be listed (Camp, 2011). At first glance this "bringing together" appears to be very fruitful in the sense that traditional boundaries are crossed. However, on further reflection questions can be raised. These questions touch upon an important issue that perpetually pervades the debates on psychiatry and religion. The issue we mean runs like this. "Psychiatry and religion" is still and only advocated by a number of indeed prominent scholars who earned their credentials, but who are also under the verdict of being strongly involved in faith or any spiritual tradition. In other words, they all have more or less, or rather, are accused of a conflict of interest (Poole & Higgo, 2011). Therefore all contributions are essentially labeled as opinion-based. Despite the evidence based on research it is still contested whether these data are relevant clinically. Because of that presumed strong conflict of interest it is still feared that the whole topic of psychiatry and religion is just to evangelize patients and is a more or less dangerous threat to appropriate boundaries in current clinical practice. In fact physicians, including psychiatrists have nothing to do whatsoever with religion and spirituality; and should not. A recent controversy among British psychiatrists is very illustrative of the ongoing debate (Dein, Lewis, & Loewenthal, 2011). In this contribution we will strive for consensus and leave science and religion as opponents behind us in favor of science and religion as allies.

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Two statements

On the occasion of the international Ávila conference "Psychiatry and Religious Experience" (November 2010) and at the World Psychiatric Association (WPA) 15th World Congress of Psychiatry in Buenos Aires last year (September 2011) we presented two statements on psychiatry and religion and on the position WPA should take in our view (Verhagen, 2012). These two statements run as follows:

1. The World Psychiatric Association, which represents world psychiatry, must change its position toward religion and psychiatry. It should do so by crossing narrow minded scientific boundaries such reductionist and materialistic boundaries.
2. Science and religion should not be regarded as opposing adversaries against each other, but as allies against nonsense and superstition.

In this contribution we will formulate a position in the religion and science debate beyond conflict in conformity with the first statement. Thereafter we will reflect on the alliance against superstition in conformity with the second statement. For a more basic discussion of this approach and the model at the root of these statements I would like to refer to my contribution just mentioned (see also Drees, 2010).

First statement: Beyond conflict

In the first place we need to draw attention to a misunderstanding. It seems to be typical to assume that both religion and science is in the realm of pure ideas. Scientific ideas are held to be impersonal knowledge of an object like and value-free world. Religious ideas consist of beliefs, doctrines, and dogmas. And the burden is placed on religious thinking to take the measure of scientific ideas; there is no corresponding challenge placed on scientific thinking. This common thought is due to a misunderstanding. Both science and religion are social practices. Distinctive for such practices are their aim, the methods used and the subject matter and content of, in our case, science and religion. In both psychiatry and religion as social practices practitioners have some ends in mind, trying to achieve certain goals. In both practices

methods and concepts are acquired, discussed and/or revised. Both practices are indeed about something, science one could say is about factual matters, religion about meaning and values. According to Stenmark (2004), that means that if we want to successfully understand how to relate science and religion, we must take into account the social structure of science and religion as social practices, the aims of both practices, the kind of epistemology they exhibit and their theoretical content. Science especially is not just object-like and value-free; for several reasons, to mention just one of them, science, as is the case in psychiatry, functions at the behest of sponsors. Funders expect science and scientific research to produce results that can be applied to meet goals. Which goals, whose goals? Commercial funders expect profitability. Governments expect these results to serve the interests of society, including health care and other social institutions, and not to forget taxpayers. Researchers are caught in a continual quest for funding grants. In other words, science is not just a matter of pure ideas. Science is culturally, economically and financially conditioned science (Hefner, 2010). This means at least two things.

In the first place, denial of this being conditioned of science inevitably means scientism. It is this scientism that made psychiatrists and pastors live in two different worlds: the psychiatrist in the world of science, the pastor in the world of meaning giving. And disease according to this scientism becomes a consequence of disruption of natural mechanisms. Anything spiritual or existential is not in order. In line with this is our second thought. With regard to medical/psychiatric practice we have to keep in mind that cultural aspects, economics and finances indeed are necessary conditions but not sufficient conditions. In its very essence, medical/psychiatric practice is not a financial transaction nor an economic business, but an ethically warranted relationship within which scientific knowledge is used for the sake of welfare of the patient.

As such, science including psychiatry becomes more and more essential for human survival, control of nature and of ourselves. And it is exactly here that the ambiguity of science becomes heightened. Success will bring us further, failure means suffering or even death. And as we know there is no unambiguous success, since there are no unambiguous outcomes. Success and failure are woven together in the same fabric of outcomes (Hefner, 2010). In psychiatry and religion we are well

aware of this fact. Repeatedly, meta-analyses have shown these ambiguous outcomes. Many studies have been performed examining this topic and the results have been varied. Some have found religion to be positively correlated with adjustment, some have found it to be negatively correlated, and some have found no significant relationship at all. So the major reviews of the literature we know of did not all arrive at consistent conclusions. Although most supported the idea of a generally positive relationship between religiosity and mental health, others reported more ambiguity in their findings. However, these data nevertheless have significance for mental health and quality of life. That means a great responsibility, and by saying that we move into the center of reflection for religion and science, not only because of that great responsibility but also because of the high levels of competence and reliability needed to come up to the mark. And to make a long story short, religion is not just theoretical thinking. It is not carried out for its own sake but rather for another purpose: to inform the discernment that seeks meaning, and to promote the common good (Hefner, 2006). And by saying that, again we move into the center of reflection for religion and science. Religion and science will concern itself with the common good. As Hefner (2006) formulates: "Religion's search to discern what is most important and science's struggle to depict the world adequately come together in religion and science in a focus on knowledge that benefits the human community. Religion-and-science is neither complete nor faithful to its own nature as a practical discipline if it does not include reflection on the common good and what behaviors are required to maintain it." (p. 575)

First recommendation

Science and religion have often been seen as enemies locked in mortal combat; an unnecessary and unfruitful stance. The locked position is clearly not acceptable and should therefore be changed. Science-and-religion, and in our case psychiatry-and-religion is not purely about description based on gathering evidence, systematic empirical testing and mathematical modeling. We need an approach of both descriptive and prescriptive aspects of our daily reality, not only how our world is, but also how it should be (Drees, 2010, pp. 63-84). Therefore we call

on WPA to reflect on its position on psychiatry and religion in order to rephrase its terms of a creative mutual interaction for the sake of the common good.

Second statement: Beyond superstition

Although superstition might sound like a phenomenon that belongs to the religious domain, that is not what concerns us here in the first place. Superstition as pseudo-religion might take modern forms disguised in psychological problems or psychopathology. There is still a lack of conceptual clarity with regard to superstition. We content ourselves here with the definition offered by Lindeman and Aarnio (2007): superstitious beliefs are "category mistakes where the core attributes of mental, physical, and biological entities and processes are confused with each other" (p. 734). The relationship between psychopathology and superstition is a rather classical one. The question is how to discern.

In a very interesting paper García-Montes and colleagues attempted to show the importance of the concept of superstition in understanding a range of psychological problems (García-Montes, Péréz Álvarez, Sass, & Cangas, 2008). Although they point at the importance of superstition in psychopathological phenomena and analyze constructs like 'Thought-Action Fusion" and "magical thinking", we will pay attention to what they call superstition as a cultural form. We will connect this with the notion of discernment (Hefner, 2006).

Each culture has its own way of being superstitious. García-Montes and colleagues (2008) formulate the following examples. A widespread form of superstition in the western world would be the belief that control over one's emotions and thoughts would be crucial for successful living. Such a belief fits in perfectly with a scientific and technological optimism that sustains the belief that one day we will be delivered from sickness and death. It also relates to a radical individualism and our consumerism. So people tend to act, as García-Montes and colleagues observe, on the only things they can (try to) change: their thoughts and their emotions. And they will do so through lifestyle, interpersonal relationships and through religious faith (Shuman & Meador, 2003). However, religion used in this way is usually called idolatry. Other

forms of superstition might be the altering of consciousness through ingestion of psychoactive substances, or the magical solutions to life's problems promoted by the advertising industry, including psychopharmaca advertising, or enhancing self-esteem. All this tends towards superstition since the changes are more "apparent than real, more magical than effective" (García-Montes et al., 2008, pp. 233-235). Self-talk, self-determination, self-actualization leads to an emphasis on the welfare of the individual as the center of his or her private universe. The risk of preoccupation with the self is not unimaginable.

If we state that thoughts and behaviors of pursuing happiness or success such as these are suspected of being superstitious and magical, and in danger of development of psychopathology, we should be able or at least should try to discern whether this is the case. Thus the notion of discernment comes in (Drees, 2010, pp. 39-40; Hefner, 2006). Discernment belongs to the domain of religion and science. Discernment focuses on what is said to be true, valuable, decisive in our lives and contributes to what meaning giving is. Spiritual discernment in that sense is a decisive intersubjective aid and a common strategy for knowing and judging developed in every spiritual tradition, even identified as gift. Our experience of the world, however, is not apart from our scientific knowledge and it depends on the context whether we must justify a particular belief in a scientific environment or explain scientific knowledge in a religious milieu. Meaning-making is established when people can take into account both the natural and the valuable. Therefore we should no longer oppose this meaningful discernment to scientific knowledge, but again our concern should be the common good.

Second recommendation

What do we mean when we say that life is meaningful? Meaning-making is not just a matter of value. When we say life is meaningful we mean that our acts and experiences cohere with other acts and experiences, with life as a whole, that acts are performed in the light of an intended purpose that makes it worthwhile in terms of values (Markus, 2004, pp. 138-144). Superstition is in danger of being incoherent with life as a whole, of being loosely connected with an intended goal or end,

and therefore stuck to hypertrophied value(s). Science and religion as allies should formulate sensible criteria and develop an appropriate attitude to discernment, based on intellectual, moral and spiritual authenticity. Therefore WPA representing world psychiatry should take its position and work on development and improvement of criteria for quality in reflections on science/psychiatry and religion against nonsense and superstition.

Discussion

The main purpose of this contribution is to move the debate on psychiatry and religion beyond mortal combat. Indeed, at first glance that seems like swimming against the mainstream of scientific and psychiatric thinking. However, it is argued here that psychiatry and religion as allies is a far more fruitful position if we manage to formulate sensible criteria for quality in our reflections on and attitude toward psychiatry and religion. It will certainly serve the mental health and common good of mental healthcare users.

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6.3 A "complex" subject matter asks for a clear lead![6]

Dr Pargament and Dr Lomax did the WPA community and readers of World Psychiatry a splendid service with their clear and well-ordered paper for the forum on "The complex interplay between religion and mental illness" (Pargament & Lomax, 2013).[7] A good service, because they managed to clear the way for proper discussion and innovative study and action towards training, continuous medical education and clinical practice. They clearly are not out to provoke or to tread on someone's toes. Their review is well-balanced, without finery, and therefore can and should be read closely. And indeed, the empirical data are self-evident.

Nevertheless, the subject matter is complex as is indicated with subtlety in the title of this forum. Why would that be the case? Are these data not as self-evident as I assume? Of course, as the authors explain briefly, there is that troubled history between psychiatry and religion. However, the field is moving, they write, to "a more nuanced understanding of religion" with regard to the promising and damaging forces religious and spiritual beliefs can have (p. 27).

6 Published as: Peter J. Verhagen, *World Psychiatry*, 2013, [Special section]*, 12*, 43. doi:10.1002/wps.20014

7 Pargament and Lomax (2013) were invited to open a forum on the complex interplay between religion and mental illness, which was followed by nine various, helpful commentaries. They argued that advances in the domain of psychiatry and religion highlight the double-edged (destructive and constructive) capacity of religion to enhance or damage well-being, particularly among psychiatric patients. Stereotyped, negative views of religion were contrasted with views that see religion as a vital resource. However, the darker sides of religious life were not denied. Therefore they stated that the growing body of knowledge points at the necessity of attending more fully to the roles of religion in psychiatric practice (diagnosis, assessment and treatment). They concluded with five recommendations to advance research and practice, especially the need for trans-cultural psychiatric studies and a final statement: "Finally, although theory, research, and practice in the area of religion and serious mental illness is still *in its early stages*, it is becoming clear that *excellence in mental health care* will involve the creation of respectful, collaborative relationships between psychiatrist and the leaders and members of religious communities" (p. 30; italics added).

Most of the time it is encouraging to be optimistic and to have positive expectations, as the authors seem to have, but I am not sure. My concerns relate to the after effects of that troubled history. Psychiatry and religion is still (and only?) advocated by a number of indeed prominent scholars who earned their professional credentials, but who are also under the verdict of being strongly involved in faith or any spiritual tradition. In other words, they (almost) all have more or less, or rather are accused of a conflict of interest. And therefore their contributions are essentially labeled as opinion-based. Despite the evidence-based on research it is still contested whether data are relevant clinically. Because of that presumed strong conflict of interest it is still feared that the whole topic of psychiatry and religion is a more or less dangerous threat to appropriate boundaries in current clinical practice (Poole & Higgo, 2012; Verhagen, 2012).

A lot of colleagues do struggle with the double-sided face of religion. Hesitating as they are, they admit that religion and spirituality might be helpful for certain patients, but at the same time they tend to underscore strongly the negative and harmful, guilt-inducing effects they have witnessed over the years.

Given this "complex" state of affairs, WPA could provide leadership. According to the WPA Section on Religion, Spirituality and Psychiatry (SRSP) it would be a major accomplishment if WPA would do so. In 2006 the SRPS and the Psychiatry and Spirituality Special Interest Group (SIG) of the Royal College of Psychiatrists in London (UK) started working on a statement that would be formulated to delineate WPA's vision on psychiatry and religion. For a WPA statement would have a certain impact and help to express a serviceable vision on the issue of "psychiatry and religion" related to psychiatric practice, research and training within psychiatry worldwide. A first revised version of such a statement was published in a WPA volume on psychiatry and religion (Verhagen & Cook, 2010, pp. 615-631). In the meantime the SIG continued its work within the Royal College of Psychiatrists, and in August 2011 a position statement drafted by Cook was accepted (Royal College of Psychiatrists, 2011).

Is the topic psychiatry and religion to be considered worthy of such attention? The SRSP thinks it is according to WPA's own criteria. And a

paper like the one on hand supports that view! In the first place it is a concern relevant to the further development of psychiatry around the world. "The changes, the transformation of religion instead of its disappearance and the place spirituality occupies are significant to psychiatry. (….) They require a renewed impulse for empirical and conceptual research into the distinction between religious and spiritual experiences on the one hand and pathological (…) phenomena on the other hand. In addition, research is needed into the significance and effectiveness of religious and spiritual healing practices around the world. There are important differences in the way these phenomena and practices are approached, interpreted and evaluated, depending on cultural and sub-cultural contexts, values and sources" (Verhagen & Cook, 2010, p. 620). A second criterion would be the availability of scientific evidence. Although complex, empirical data are available and an overwhelming amount of research support these findings. That is not the problem. The problem is how to get these data, their interpretation and application noticed by mental health professionals, psychiatrists in particular. Therefore, as Pargament and Lomax (2013) argued, psychiatric training should be updated in order to get psychiatrists ready to readjust their attitude and to deepen their knowledge. Public visibility, as a third criterion, is high. Mental health is a political and public theme. "Psychiatry and religion" responds to this requirement. In the fourth place, would the absence of such a statement be harmful to psychiatry and to psychiatric patients? If it is true that the individual yearns to be understood in his or her uniqueness and to be the focal point of clinical practice, then inevitably religion is at the heart of that patient centered focus. Religiosity and spirituality are positive, can be subject to doubt, "can be corrupted", but, as Sims declares, "cannot be classified as (a) morbid or psychiatric" conditions (Sims, 2011, p. 70).

Therefore, the SRSP holds the view that the topic of "psychiatry and religion" concerns psychiatry worldwide and that consequently a statement deserves priority. We call upon WPA to take this lead.

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6.4 WPA Position Statement on Spirituality and Religion in Psychiatry[8]

The WPA and the World Health Organization (WHO) have worked hard to assure that comprehensive mental health promotion and care are scientifically based and, at the same time, compassionate and culturally sensitive (Bhugra, 2014; Saxena, Funk, & Chisholm, 2014). In recent decades, there has been increasing public and academic awareness of the relevance of spirituality and religion to health issues. Systematic reviews of the academic literature have identified more than 3,000 empirical studies investigating the relationship between religion/spirituality (R/S) and health (Koenig, King, & Benner Carson, 2012; Koenig, McCullough, & Larson, 2001).

In the field of mental disorders, it has been shown that R/S have significant implications for prevalence (especially depressive and substance use disorders), diagnosis (e.g., differentiation between spiritual experiences and mental disorders), treatment (e.g., help seeking behavior, compliance, mindfulness, complementary therapies), outcomes (e.g., recovering and suicide) and prevention, as well as for quality of life and well-being. The WHO has now included R/S as a dimension of quality of life (WHOQOL SRPB Group, 2006). Although there is evidence to show that R/S are usually associated with better health outcomes, they may also cause harm (e.g., treatment refusal, intolerance, negative religious coping, etc.). Surveys have shown that R/S values, beliefs and practices remain relevant to most of the world population and that patients would like to have their R/S concerns addressed in healthcare (Moreira-Almeida, Koenig, & Lucchetti, 2014; Pargament & Lomax, 2013; Verhagen, Van Praag, López-Ibor, Cox, & Moussaoui, 2010).

8 Published as: Alexander Moreira-Almeida, Avdesh Sharma, Bernard Janse van Rensbug, Peter J. Verhagen, & Christopher C.H. Cook, *World Psychiatry*, 2016*, 15*(1), 87-88.
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Psychiatrists need to take into account all factors impacting on mental health. Evidence shows that R/S should be included among these, irrespective of psychiatrists' spiritual, religious or philosophical orientation. However, few medical schools or specialist curricula provide any formal training for psychiatrists to learn about the evidence available, or how to properly address R/S in research and clinical practice (Cloninger, 2013; Moreira-Almeida et al., 2014).

In order to fill this gap, the WPA and several national psychiatric associations (e.g., Brazil, India, South Africa, UK, and USA) have created sections on R/S.[9] WPA has included "religion and spirituality" as a part of the "Core Training Curriculum for Psychiatry" (World Psychiatric Association, 2002).

Both terms, religion and spirituality, lack a universally agreed definition. Definitions of spirituality usually refer to a dimension of human experience related to the transcendent, the sacred, or to ultimate reality. Spirituality is closely related to values, meaning and purpose in life. Spirituality may develop individually or in communities and traditions. Religion is often seen as the institutional aspect of spirituality, usually defined more in terms of systems of beliefs and practices related to the

9 The Dutch Association for Psychiatry does not have a comparable section or special interest group like that. In 2000 the Dutch Foundation for Psychiatry and Religion was established on the initiative of Dr. Herman M. van Praag and Dr. Gerrit Glas. The main purpose of the Dutch Foundation is to improve the relationship between psychiatry and spiritual care giving. It also encourages research on the interface between psychiatry, religion and spirituality. It also encourages the dissemination of knowledge and scientific data on religious and spiritual issues, in relation to psychiatry and allied domains. The Foundation organizes national and international conferences, workshops, professional training and public lectures. Other organizations are also active in this particular field. Two of them are the KSGV and the CVPPP. The KSGV, founded in 1930, is an independent Dutch association that aims to explore the relationship between faith/religion/meaning and mental health. It is chaired by Dr. Marinus H.F. van Uden (Retrieved from https://www.ksgv.nl/het-ksgv/summary/). The CVPPP is the Dutch Christian Association for Psychiatrists, Psychologists and Psychotherapists. It focuses on the relationship between Christian faith and the fields of psychiatry, psychology and psychotherapy. Website https://cvppp.nl/

sacred or divine, as held by a community or social group (Koenig et al., 2012; Verhagen et al., 2010).

Regardless of precise definitions, spirituality and religion are concerned with the core beliefs, values and experiences of human beings. A consideration of their relevance to the origins, understanding and treatment of psychiatric disorders and the patient's attitude toward illness should therefore be central to clinical and academic psychiatry. Spiritual and religious considerations also have important ethical implications for the clinical practice of psychiatry (Cook, 2011). In particular, the WPA proposes that:

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;
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;
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;
4. The approach to religion and spirituality should be person-centered. Psychiatrists should not use their professional position for proselytizing for spiritual or 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;
5. Psychiatrists, whatever their personal beliefs, should be willing to work with 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;
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;

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 a critical but impartial way with the wider community in support of the promotion of health and well-being.

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Chapter 7

Psychiatry and religion: Consensus reached![1]

WPA Section on Religion, Spirituality and Psychiatry

In this report I will briefly sketch the history and activities of the World Psychiatric Association (WPA) Section on Religion, Spirituality and Psychiatry. I will then continue with the topic in order to reach a consensus on the importance of religion and spirituality in psychiatry for the welfare of our patients. It turned out to be a project of much endurance. Therefore, I called upon WPA to take the lead in this sensitive matter (Verhagen, 2013). I will discuss the final result as it was published in the WPA journal World Psychiatry (Moreira-Almeida, Sharma, Janse van Rensburg, Verhagen, & Cook, 2016).

After founding the Section in 2003 I served the Section as secretary and the last two terms as chair.[2] In 2014 I was succeeded by professor Alexander Moreira-Almeida from Brazil.[3]

It was really a pleasure and a privilege: especially the creation of a worldwide network was a very inspiring experience. We managed to connect many colleagues with various religious and spiritual backgrounds around the globe. The Section and regular symposia we organized at many WPA occasions not only demonstrated the interest of many in our field of inquiry, it also made clear that colleagues around the world are convinced of the importance of the issue of religious and spiritual needs in patient care, in training and in research. Our efforts

1 Published as: Peter J. Verhagen, *Mental Health, Religion and Culture*, 2017, [Special Issue]*, 20*(6), 516-527. doi:10/1080/13674676.2017.1334195

2 Founding chair emeritus professor Herman M. van Praag (the Netherlands) and co-chair professor Driss Moussaoui (University of Casablanca, Morocco).

3 Director of the Research Center in Spirituality and Health (NUPES) at the Federal University of Juiz de Fora.

resulted in the section a handbook on religion and psychiatry, edited and written by WPA officers and section members (Verhagen, Van Praag, López-Ibor, Cox, & Moussaoui, 2010) and recommended by the then WPA president professor Mario Maj. In 2012 we were able to release our Newsletter *Psyche & Spirit: Connecting Psychiatry and Spirituality* (Editors: Alexander Moreira-Almeida, Simon Dein, & Peter J. Verhagen). Again and again we are told that the work of the Section is highly appreciated by WPA!

One of the highlights of all the symposia and conferences was certainly the International Symposium on Psychiatry and Religious Experience in Avila, Spain, November 2010, with reference to the publication of the handbook. A conference so well and most generously organized by the López-Ibor Foundation, and chaired by the late professor Juan J. López-Ibor, past president of the WPA. Papers presented at the conference were published in a special issue of the Actas Españolas de Psiquiatría, Vol. 40, Supplement 2, December 2012 (López-Ibor et al., 2012). This conference was followed by the 1st Global Meeting on Spirituality and Mental Health in Brazil in 2015 (Moreira-Almeida, 2015), and a year later by the 2nd Global Meeting in Cape Town, November 2016. And now (in the beginning of 2017) we are looking forward to the 3rd Global Meeting during the WPA World Congress in Berlin, October 2017.

Directly from the beginning we were spirited and eager to develop a statement on religion, spirituality and psychiatry in order to draw the attention of the whole mental health professional community to this special field of interest. From 2006 on we have collaborated on this with the Special Interest Group Spirituality and Psychiatry of the Royal College of Psychiatrists in London (Verhagen & Cook, 2010). Finally, in December 2015 the Executive Committee (EC) of the WPA accepted the proposal! This time, under the leadership of Alexander Moreira-Almeida, the last hurdle was taken successfully.

Would it be possible to reach a consensus on psychiatry and religion?

When we started in 2006 the question was whether it would be possible to formulate a consensus on psychiatry and religion among

psychiatrists and mental health professionals worldwide. Professional organizations such as national organizations and also international organizations such as the World Psychiatric Association take it as their responsibility to highlight topics of special concern in the field of our work whenever necessary. And if possible so-called position or consensus statements are developed. And if one looks at such statements one can easily understand that there are special reasons and concerns why of all these topics were formulated. "These statements seek to express the consensus of the world psychiatric community on questions relevant to the limits, practice, research and education in psychiatry", as quoted from the WPA manual of procedures with regard to the tasks of the Executive Committee (http://www.wpanet.org). Sometimes these topics are of particular importance to minorities among psychiatric patients. Other topics are more or less controversial among stakeholders involved and are in need of a firm position adopted by the psychiatric community.

The WPA does not accept just any proposal for a consensus statement. In order to be considered worthy of such attention, a topic must fulfil a number of conditions. The topic has higher priority if:

- It is a concern relevant to the further development of psychiatry around the world (topics of only national or regional interest are given less priority);
- Scientific evidence is available to support the importance of the topic;
- Member societies have expressed their need for such a statement;
- It is of greater public visibility and consequently likely to have more impact;
- The absence of a consensus could be harmful to psychiatry or psychiatric patients.

In our view "Religion and Spirituality" was and is such a topic in need of a plain point of view, shared by the psychiatric community worldwide. Therefore, it is necessary to explain convincingly that the topic of "psychiatry and religion" fulfils these criteria.

The biopsychosocial model extended

However, before continuing we must look for a model, at least a heuristic model that could possibly explain in a reasonable way that religion, spirituality and meaning giving should be looked at as an integral element of human (psychic; subjective) functioning. Such a model is available although not undisputed, and is known around the world as the "Biopsychosocial model" (BPS). For the sake of the argument we will take it for granted that we all are familiar with the model and that we all do our clinical work with this model in mind. That seems a reasonable guess for our purpose here. From the perspective of systems theory, the idea is that biological, psychological and social factors are organized levels (systems) of different complexity that interact in a complex way in health and in disease (Hefti, 2009, 2013). Each system is related to every other system, but the language and methods for one system cannot be applied one-on-one to another system. In our clinical work we consider these three systems simultaneously in an often openly eclectic way. If there is room for improvement in any of these systems, the psychiatrist and the patient will work together toward that end. And any improvement in one system is assumed to result in some improvement in the other systems as well.

However, one of the main criticisms of the model is that it fails to open up to more meaning centred, and meaning driven aspects of human desires and psychic life. Engel, whose primary concern was how psychiatry could be maintained as a part of medicine, saw his model "not as a matter of compassion and humanity, but one of rigorous application of the principles and practices of science" (Lewis, 2007, p. 300). This resulted in the fact that his psychological level is not differentiated enough. Besides, his social level is highly individualistic, so that the effect of social and political dynamics on mental health outside family and workplace falls short. The model is limited "inasmuch as it disregards such clinically important considerations as patients' subjective experiences and narratives of illness" (Brendel, 2007, p. 312). In fact, this points to one of the major problems in psychiatric thinking: the elimination of the mind.

Without doubt psychiatric care involves a multidisciplinary multilevel model of care. The bio-psycho-social model of course aims at addressing the whole person. It underscores the need for a holistic view

and in that respect fulfils a necessary condition, but it is not sufficient enough. A solution could be adding another distinct and interdependent level, as has been proposed. Integrating religion and spirituality asks, it is said, for a so-called bio-psycho-social-religious/spiritual model. Such a model would make it clear that religion and spirituality can be causal, mediating or moderating factors on mental health and disease (Hefti, 2009). Just summarizing the well-founded opinion of many colleagues: Religion and spirituality affect biological, psychological and social aspects of human life (Culliford & Eagger, 2009), "and all domains affect each other, including the spiritual" (Huguelet & Koenig, 2009, p. 2).

Merely adding a fourth level to the BPS is not enough, mainly because it does not explain very much. It is not very clear how these four qualitatively different systems interact. In connection with this, one should realize that general systems theory has evolved enormously. De Haan (2015) proposed an enactive approach of the four main dimensions that are at stake based on the thesis that matter and mind are not opposed, but fundamentally go together in embodied living beings. In that sense, physiological and existential/experiential processes should not be opposed, but examined from the perspective of the "complex person-world system as a whole" (p. 214). This seems to me a very promising and enriching approach.

Importance of the topic

Is the topic of Religion and Spirituality really a concern relevant to the further development of psychiatry around the world? From the beginning we were convinced it was. "It has repeatedly been argued that religion is a forgotten or lost dimension in psychiatry, but it is now commonly said that there is a growing awareness of the importance of religion and spirituality among psychiatrists and in mental healthcare. (….) Psychiatrists once more recognize that their patients' spiritual experiences and religious practices are important" (Verhagen & Cook, 2010, p. 618). It is very clear that figures give us a clear indication of the enormous numbers of people belonging to the world's major religions. And these numbers are quite apart from the almost infinite

diversity and continuing emergence of new religious and spiritual groups.

However, psychiatrists are still reluctant and undecided as to how to respond to this appeal. There is still concern that psychiatrists might become trapped into imposing their own beliefs on patients and/or putting pressure on patients to discuss or justify their beliefs (or the absence of them). Yet it is curious when one considers that all ethical guidelines agree on this point: doctors should not discuss their personal beliefs unless these beliefs are relevant to patient care, and doctors should not impose their beliefs on patients. Psychiatrists should not substitute their own commitments or any religious/spiritual ritual for professionally accepted diagnostic methods or therapeutic practice. There is no misunderstanding about this (American Psychiatric Association, 1990, 2006). The point is that "for some patients, acknowledging their beliefs or religious practices may be an important aspect of a holistic approach to their care. Discussing personal beliefs may, when approached sensitively, help you to work in partnership with the patients to address their particular treatment needs. You must respect patients' right to hold religious or other beliefs and should take those beliefs into account where they may be relevant to treatment options" (General Medical Council, cited by Cook, Powell, Sims, & Eagger, 2011, p. 39).

To put it another way, no longer can psychiatrists in a multi-faith, multi-cultural globalized world hide behind the dismissal of religious belief as pathological, or behind biomedical scientism. Globalization affects psychiatry, as it affects religion and spirituality. Globalization is not just the international exchange of goods and services of the commercial kind, but also the export of religious ideologies, spiritual and religious goods and the like. The import of mindfulness in psychiatric practice is a typical example. Anyway, spirituality, religion and globalization all have a vital impact on overall wellness and quality of life for an increasing number of the world's inhabitants (Kale, 2004).

As far as I can see all representatives of the major religious traditions who contributed to our book agreed with this point of view. A change of attitude is what psychiatrists need for the benefit of their patients. A consensus on this could underscore this aspect of clinical practice. Originally, in 2010 we formulated this point as follows: "Whatever disagreements there might be on definition, spirituality and religion

are concerned with the core beliefs, values and experiences of human beings. A consideration of their relevance to the origins, understanding and treatment of psychiatric disorders should therefore be a central part of clinical and academic psychiatry. Spiritual and religious considerations also have important ethical implications for the clinical practice of psychiatry" (Verhagen & Cook, 2010, p. 630). These words are confirmed in the accepted position document (Moreira-Almeida et al., 2016). As Gabbard and colleagues formulated it in their widely recognized text on professionalism in psychiatry, respect for the person means treating the other with "genuine consideration and attentiveness to that person's life history, values, and goals" (Gabbard et al., 2012, p. 22). Which by the way also means that the professionals need to be aware of their own (religious, spiritual, and meaning-making) commitments as these influence their attitude and the way in which they practise their professional roles.

Scientific evidence

Is scientific evidence available to support the relevance of the topic? Extensive research has been conducted and comprehensive data are available, but the relationship between religion, spirituality and mental healthcare is still disputed (Verhagen & Cook, 2010, p. 620). Among many others Braam (2009) summarized a few of the empirical findings. (a) There is extensive evidence that religiousness relates to some degree to better mental health in the community and represents a source of adaptation in times of adversity. (b) There is some evidence that the recovery rate from depression is substantially better for patients who attach intrinsic value to their religious faith and patients involved in a religious community. (c) Cross-sectional examination of the relationship between social support, religiosity and anxiety shows that greater religiosity is related to lower state anxiety. Strong religious beliefs may facilitate coping with existential issues, whereas those who hold weaker beliefs may demonstrate heightened anxiety. However, the investigation of religious and spiritual issues in anxiety lags behind research on depression and psychosis. (d) Research shows that religion and spirituality rather than triggering psychotic symptoms can provide powerful coping mechanisms (Huguelet and Mohr, 2009).

There is a long list of not only interesting but also necessary research topics and conceptual analyses that are required to be done. I mention just two of them that rightly attracted a lot of interest: religious coping (Van Uden, Pieper and Zondag, 2014) and the effectiveness of incorporation of religious or spiritual perspectives into psychological therapies (Anderson et al., 2015).

Improvement of empirical research

Another important aspect to underline is the fact that empirical research has improved over the years, and research syntheses have improved as well. If one compares the early reviews with the more recent examples one cannot fail to notice the improvements. One of the first reviews, from the pre-evidence-based era, was published in 1969 by Sanua in the *American Journal of Psychiatry*. In fact, he presented a quite original approach. He divided the studies he had found according to five domains, but claimed that he had not been able to find any empirical support for the common belief at that time that religion would be a basis of sound mental health. However, as a review from the pre-evidence-based era the interpretation appears to be more or less opinion based in our eyes today; no quantitative analysis of outcome measures, no information concerning how and on which grounds studies were selected and included or not, and so on. Therefore, this review now seems quite questionable today.

A quite different picture is presented by the review written by Bonelli and Koenig (2013). They searched the period 1990-2010 and found 43 studies that met their criteria. They also used criteria for rating the quality of each study, which is an important addition and improvement given the usual criticism of studies on religion and mental health.

They divided the results according to diagnostic groups following ICD-10. Results: 72% of the studies reported a positive relationship between religious involvement and better mental health. Although more than 40 different measures of religion/spirituality were used in these studies, all assessed the degree of involvement. Regarding the diagnostics groups, all studies on dementia (2), suicide (3) and neurosis (3) found a positive association, 79% of the studies on depression (19) and 67% of those on substance abuse (9). Most findings in schizophrenia (5) were mixed or positive, in bipolar disorder (2) mixed or negative.

According to their rating of the quality of studies before and after 2000 they found an improvement in quality of methodology and design.

The authors conclude that their findings are similar to those reported by earlier reviews, and that research has improved. That does not mean that there are no methodological issues remaining. To mention a few: Religion and spirituality are multidimensional constructs, and therefore it is necessary to specify which dimensions are assessed. Especially spirituality is a difficult concept if one wants to avoid an all too large similarity with religion or mental health. And what exactly is meant by non-religiousness, atheism or agnosticism? Another issue is the fact that most studies are cross-sectional, therefore giving no indication about causality. Religious factors may function in different ways across the life span. And one should always realize that it is not always clear for what reason people are religiously involved, including reasons that have nothing to do with religious beliefs (e.g., "risk avoidance").

There is far more to say. Much of this research has been conducted in the West (mainly in the United States of America) and with Judeo-Christian groups of subject. Fortunately, more research from other parts of the world including the Arabic world is on its way. Nevertheless, empirical evidence reveals a largely positive relationship between religiosity/spirituality and different indices of health. However, caution requires us to stress that religious and spiritual beliefs are powerful forces and may impart harmful effects as well (Graham, 2015).

Is there a need for consensus?

The third criterion is that consensus should be reached if professional/member societies have expressed the need for such a consensus. Several professional organizations created special groups or sections on religion and psychiatry. One of the most well known examples is the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists in London (UK). But also in Germany, Brazil, South Africa, and the United States such groups have been founded. In other countries colleagues would like to have such a group, like the one in Italy. In the Netherlands we have the Dutch Foundation on

Psychiatry and Religion and the Christian Association for Psychiatrists, Psychologist and Psychotherapists. So there is a growing awareness. Even more important, at least four of these national associations accepted a consensus document: the APA, the Royal College of Psychiatrists (RCP), the South African Society of Psychiatrists, and the Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde (DGPPN). I mentioned the APA document earlier. The RCP approved a position statement in 2011, written by C. Cook (RCP, 2013). The South African Society of Psychiatrists published guidelines for the integration of spirituality in psychiatry a year later (Janse van Rensburg, 2014). The DGPPN Task Force published its statement online December 2016 (Utsch et al., 2017).[4]

I already pointed at the discussion with regard to ethical guidelines and the professional attitude. A consensus would also be in favor of the necessary multicultural competence and sensitivity of mental health professionals including the issue of self-disclosure (Magaldi & Trub, 2016). Is it not true that today we are far more convinced that self-disclosure can have a positive impact on the working alliance, although one should always be aware of possible negative effects? Consensus is required to support this point of view.

Consensus is also necessary with regard to research. Multicenter international research programs including large groups of patients too often do not include a religiosity/spirituality scale or measure. To give an example: only recently did The Netherlands Organisation for Health Research and Development (ZonMw, 2016) draw attention to the importance of religion/spirituality and meaning-making in health care and research in one of its recommendations (ZonMw funds health research and promotes the actual use of the knowledge this research produces).

4 Actually there are five documents. The Indian Psychiatric Society "Spirituality and Mental Health" Task Force (2008-2009) published practice guidelines (Sharma [Ed.], 2009). However, it has not yet achieved the status of position or consensus statement.

The public domain

WPA's fourth criterion: is "religion in psychiatry" likely to have high visibility and does the impact of that fact require higher priority? Health is a political and public theme. Officially, religious and spiritual well-being is not part of the WHO definition of (mental) health. This is seen by many as a shortcoming of the definition, but arguably it is politically unrealistic to expect agreement on religious well-being. For, if governmental organizations were expected to pursue this, they would risk being accused of "meddling with" religious issues. Besides, which religion(s) would be singled out? Such an approach would likely lead to hopeless complications. Yet, the religious domain is part of the "Quality of life" measures developed by the WHO (WHOQOL SRPB Group, 2006; Verhagen & Cook, 2010, p. 621).

However, a new definition of health has been proposed and is increasingly being accepted, and yes it includes the spiritual/existential dimension. It is increasingly agreed upon that spiritual and existential issues belong to the domain of personal recovery. This is a very important development. "Religion and spirituality are sources of support and coping in circumstances where life seems unmanageable. They can stimulate positive experiences such as hope and optimism, but also traditionally provide the means to cope with transitional phases in life such as birth, marriage, illness and death" (Verhagen & Cook, 2010, p. 621).

And if not?

Finally, does it matter if there is no WPA statement on religion, spirituality in psychiatry? Given the facts and considerations I have explained we think it does. What should be underlined is that psychiatry is about more than just making a DSM or ICD diagnosis. One can excel as a psychiatrist or mental health professional when one does understand the individual in his or her uniqueness and when that unique person is the focal point of clinical attention. Not to do so inevitably leads to deficient healthcare. Spiritual and religious concerns will often (even if, as some might argue, not always) be at the heart of that patient centered focus. A consensus provides important counterbalance to

traditionalism and empiricism, and particularly to the impoverished hyponarrativity of the psychiatric (DSM) tradition (Sadler, 2004).

Desideratum: From conflict to dialogue

With the approval of the statement an important movement has been made. Not long ago, and it is still alive, the relation between science and religion was one of conflict, "a deadly dance" (Wilber, 1998): science denies any validity to religion; religion has solid criticism to scientific claims. In fact, empiricism, the assumption that reliable knowledge is based on our perceptual experience, is originally a religion-critical position. In that sense classification systems such as in the DSM tradition bear an inborn criticism to intuition, faith or divine insight (Sadler, 2004, p. 176). The milder position is independence. Now we have no conflict or problem because science and religion are two domains that are completely separated from each other. They differ fundamentally with regard to the questions asked, the claims made, and the methods used. Their languages have different functions. Although milder this position is just as unsatisfactory as the previous one, simply because there are no such watertight compartments.

The WPA position statement aims at least at dialogue. This aim runs in two directions. First of all, although empirical facts can be undisputable it is still possible and even necessary to have a dialogue on presuppositions (e.g. about human nature), on normative views, and on how results are influenced or interpreted by these assumptions and views. In fact, the WPA position statement invites such a dialogue. The second direction concerns the dialogue between the participants involved, to start with the psychiatrist and the patient, and by extension on all levels in mental health care. The WPA position statement gives prominent attention to this aspect.

In conclusion

Since 2004 Section members have worked hard on this and yes, in 2015 a WPA Position Statement concerning psychiatry and religion was accepted by the EC of WPA. Clearly the EC concluded that the topic

of religion, spirituality and psychiatry meets the demands set by the WPA, both as far as psychiatry itself is concerned, and also politically and socially worldwide. The EC sees such a statement as harmonizing very well with WPA's ethical views. This is not to deny that much work is still required. More research is needed, and numerous cultural sensitivities must be addressed. Understanding between psychiatrists of different cultures, spirituality and faith tradition may be every bit as sensitive as that between psychiatrist and patient. It requires mutual respect, patience, empathy and a desire to understand the other better. However, this, in itself, is a kind of spiritual task.

We therefore continue to seek agreement, acknowledging respectfully that we must fully acknowledge the perspective of other colleagues if we are to achieve anything worthwhile. I have confidence in the international friendships that have been established by our common vocation of psychiatry. Through these friendships we hope to pursue honestly and courageously our professional role in the spirit of the consensus that will transcend our differences. Finally, I am grateful to all colleagues who continue working with us towards this end, even when their personal convictions oblige them to disagree with us.

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Chapter 8

Spiritual life and relational functioning A model and a dialogue[1]

Introduction

During the last decennia it has become more clear to an increasing number of psychiatrists and psychotherapists, that taking the faith life of clients into account can be very relevant for therapeutic progress. As a result of this increasing professional interest, the past three decades have shown an increasing amount of literature and research on this subject. In view of this, psychiatrists and psychotherapists must be sufficiently knowledgeable about it in order to assess its influence on their clients' problems, to prevent linguistic misunderstandings, to decide whether pastoral help should be called in or not, and to help clients to find solutions within their own religious frame of reference.

Nevertheless it is still an uncomfortable theme in mental health care, and despite many discussions it is still not quite clear how it could be integrated. This is not surprising, because we have to deal here not with one problem area, but with at least seven problem areas, each of them in itself complicated and each of them interwoven with the other ones:

1. The function of religion/spirituality as a comprehensive meaning-making framework in which problems become problematic in a certain way and in which certain therapeutic approaches can become effective or counterproductive (Cobb, Puchalski, & Rumbold, 2012; VanderWeele, 2017; Verhagen, Van Praag, López-Ibor, Cox, & Moussaoui, 2010).

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2. The diversity on the map of the religious and spiritual landscape, and the particular language that is used (Berghuijs, Pieper, & Bakker, 2013; Keller, Streib, Silver, Klein, & Hood, 2016).
3. The diversity of therapeutic schools and their methods.
4. The uncertainty about how to diagnose religion/spirituality-laden problems (Verhagen, 2013).
5. The ethical boundaries of the therapeutic profession; it is inadmissible to try to dissuade clients from their religion/spirituality, even if we are convinced that it is bad for their mental health (Peteet, Dell, & Fung, 2017).
6. The philosophy of life which is implicit in every therapeutic methodology. Therapeutic methods are not ideologically neutral, so therapists must be aware that subconscious prejudices implicit in a particular method and its concepts can inhibit communication with some clients (Schreurs, 2002).
7. The philosophy of life of each therapist. Therapists must be aware of how their own cultural and professional socialisation may affect their listening and responding to clients (Glas, 2017; Verhagen, 2017).

Because of this complexity, it is an illusion to think that one or a few individuals can design a coherent and workable diagnostic system. This requires an ongoing interdisciplinary dialogue among colleagues about how to take account of these problem areas. We all know, however, how easily such many-sided problems give rise to interminable discussions. In order to arrive at workable results, this many-faced dialogue needs a structure.

This article argues in favour of using a relational framework for spirituality from a Christian perspective. In contemporary thinking, there exists more or less consensus with regard to relatedness as fundamental characteristic of being human. In psychology of religion there is a tendency to take relationality as organizing principle for understanding human development and functioning and to conceptualize spirituality in relational terms (among many others Davis, Hook, Van Tongeren, Gartner, & Worthington, 2012; Kirkpatrick, 2005; Tomlinson, Glenn, Paine, & Sandage, 2016; Worthington & Sandage, 2016). We see relationships not just as something that comes to the person from the outside, but that our relatedness is constitutive for partners in their relationships. Our way of reasoning is based on two assumptions, on

love as a key notion and on the primacy of relatedness over the individual person.

Before explaining the model we will make three brief preparatory remarks with regard to what relational spirituality is, to dialogue as an approach of the psychiatry–religion controversy, and to the primacy of relatedness.

What is relational spirituality?

It is our intention to contribute to the research on theories in psychology of religion on relational spirituality, self and relational functioning. Our contribution is not empirically oriented (Augustyn, Hall, Wang, & Hill, 2017; Tomlison et al., 2016), but conceptually (Brümmer, 1993, p. 157; LeRon Shults & Sandage, 2006), and dynamically oriented (Jones, 1996; Rizutto, 1979; Schreurs, 2002). In an excellent overview Tomlinson and colleagues formulated five categories of what is meant by relational spirituality. We assume that our model reasonably fits in the fifth category, what Tomlison and colleagues named the "Differentiated-based model" (Tomlinson et al., 2016). This requires a brief explanation. Both LeRon Shults and Sandage (2006) define relational spirituality as "ways of relating to the sacred", whatever people may consider sacred (pp. 25, 161; Sandage & Harden, 2011). Three elements are important in their understanding of relational spirituality: one's experienced relationship to the sacred, the interpersonal relational systems, and the process of individual spiritual development. These three aspects are interwoven with a whole series of interdisciplinary perspectives. A differentiated model is comprised of a combination of these perspectives, such as attachment theory, contemporary psychoanalysis, and also neurobiological and neurological views, is what it makes a differentiated model. Our approach adds a particular theological point of view and starts from the view that spiritual relationships are (in part) analogous to human relationships. Therefore we take "relational spirituality" as referring to how religious people perceive their relationship with God. Such a perception may be theologically adequate or inadequate, and may be psychologically supportive or harmful.

Of special importance in the relational approach of Sandage and colleagues is the construct of differentiation of self (DoS). This refers to the capacity to balance thoughts and feelings, to lessen one's emotional reactivity, to self-soothe in the face of anxiety (intrapersonal dimension) and to balance connection and independence, to maintain a distinct sense of self while connecting with others, to establish clear boundaries for oneself, and to initiate and receive intimacy voluntarily (LeRon Schults & Sandage, 2006; Majerus & Sandage, 2010; Sandage & Harden, 2011; Sandage & Jankowski, 2010). We also will take into account the importance of the DoS for our approach as especially will be shown in the second part of this paper about spirituality in psychiatry.

Model and dialogue

One of the strategies to support and to bring about change of attitude among mental health professionals is of course presenting new models which have the potency to offer new perspectives on diagnostic and therapeutic questions in clinical practice. It would be of special interest when such models offer the possibility of integrating religious or spiritual aspects. One of the intriguing questions, out of many, is how to understand the nature of persons and their relationships from a religious or spiritual perspective. Or, formulated in a more subtle way, could a religious or spiritual perspective on persons and their relational functioning be helpful in clinical practice by spreading new light on that specific topic? That could be the case if the proposed perspective would offer a more differentiated picture and encompassing model of spiritual life in connection with personal and relational functioning than the mental health professional is accustomed to. It would also be helpful if the model could offer a tool that helps to find recognizable patterns in the enormous variation in spirituality. It is impossible to have knowledge of all these variations in detail.

In this article we want to present such an innovative perspective on persons and relationships, as we stated earlier, based on love as a key notion and on the assumption of the primacy of relatedness over the individual person. The explanation of the model is followed by a proposal for opening a dialogue on the model and the alternative model for personality functioning as it is described in DSM-5™ (APA, 2013, pp.

761-781), in order to evoke a greater awareness on the potential possibilities of the model. With such a dialogue we do not merely mean a more or less interesting, routine conversation among professionals about a new idea. We do mean dialogue in the specific meaning of an approach to the "psychiatry religion controversy" (Barbour, 2000).

Relatedness is primary

We usually make a distinction between relatedness and relationship (Schreurs, 2002, 199-200). Relatedness aims at an aspect of existence, of being. Being is understood as being-with-others. "All real living is meeting", and "in the beginning is relation", as the well-known philosopher Martin Buber stated in his famous *I and Thou* (*Ich und Du*, reprinted 1923/1937, pp. 11, 18), meaning that not individuals but relationships are primary. Embedded in a network of relationships individuality arises out of relational experiences, and not the other way around (also Van Uden, 1985). This is not just a matter of the very beginning but it continues to be important for our entire lives. Our identity and our value as persons are largely determined by fellowship with others. That is, I have my own characteristics that make me the person I am, my ideas, convictions, emotions and needs, wishes and desires, which give purpose, value and coherence to my own life and actions. However this authenticity is a necessary condition for having my identity as a person, but it is not sufficient. It is here that the relational aspect of having a personal identity comes into the picture. We need others in order to develop as full and authentic human beings. To quote the Dutch philosopher of religion Vincent Brümmer (1993): "Since in this way both our identity and our value as persons is constituted by our relations of fellowship with others, we *need* to partake in such relationships. As persons we therefore *necessarily* long both to love and to be loved" (p. 235; emphasis in original). That is what we mean by relatedness, nothing less than a fundamental characteristic of being human and human development. This also means that being a person, the self and DoS are embedded in that relatedness. Among others, it was James W. Jones who paid special attention to the significance of Buber's relational theology in the development of what Jones called a "relational psychoanalysis of religion" and "a relational psychoanalytic

investigation" of the sacred (1996, 1997, 2001; see also Yalom, 1980, pp. 364-373). With his approach Jones (1997) suggests that a relational understanding of human nature would possibly clarify how religious and spiritual forms "embody various relational themes" (p. 139). This embodying of relational themes is what we intend to show with our approach.

At this point we can make the link with what has been said about relational spirituality. In spiritual life we can stipulate the same. Spiritual life is characteristically and by definition relational life. Spiritual relatedness refers to our being in a state of inter-subjectivity with others, with the supreme Other, or whatever we call it (e.g., transcendent reality). That holds true whether we are aware of it or not. In spiritual relationships we see the particular way in which individuals and communities construe their involvement or connectedness with the Transcendent. Relatedness as a fundamental characteristic of human being and human development, putting it in a Christian perspective, is in that sense the fundamental implication of being created in the image of God. Which means among many other things that God is the ultimate source of endorsement and recognition of the person I am by the forgiving grace of God.

If that is true, it would be helpful to have an instrument or a perspective to assess interpersonal relationships and spiritual relationships, and their interwovenness. If that would be possible it would not only be helpful in getting a more clear view on somebody's interpersonal and spiritual relationships, it would also help to assess (problematic) relational functioning and to look at the potential for change in either one or both domains of relational functioning.

Consensus on relatedness

In contemporary theology (anthropology and psychology of religion) there is a more or less (growing) consensus with regard to relatedness as a fundamental characteristic of being human. Relationships are therefore not only something that come to the person from the outside, but relatedness is constitutive for the persons in their relationships. The German theologian Schwöbel (2011) explains that when we understand relationships in this way we see a passive and an active

dimension. Humans are embedded in a relational network. That network is already there before they are there ("always others [like parents] have begun with me"; Glas, 2006, p. 133; Jones, 1996). These relations pertain to the relationships to the Other, to the world around and to the self. However, these relations challenge us and the Other to give shape to these relations. That is in a certain way what the biblical narrative is about. We could also say that from a biblical perspective relationships are the communicative form by which we learn who God is and how God is, who the human being as creature is and how humans act and relate.

This relational perspective is important in another way as well. In fact, we no longer restrict our definition of the human being by this or that capacity or incapacity for instance as a rational being or based on a hierarchy of needs as Maslow proposed (1954), or by states and traits. When we characterize the human being as a relational being, human capacities, needs, or other properties (skin color, age, gender) are situated within that relational network, and vice versa (Schwöbel, 2011, pp. 276-277).

A model

So far for the three introductory remarks; we now continue with the explanation of the model. The Dutch philosopher Vincent Brümmer groups interpersonal and spiritual relationships into three identifiable basic types (Brümmer, 1993). Love is the key notion of the model, and primacy of relationships is the basic assumption. The three categories he stipulated are named "impersonal" (or "manipulative") relationships, "agreements about rights and obligations" (or "contractual" relationships) and "mutual love" (or "fellowship") relationships. As a philosopher of religion his purpose is to show how these three basic categories function as root metaphors or key models in various theologies. If you are able to analyze a theology you will find that the relationship between God and humans/persons it implies is modeled as an analogy

to one of these basic types of spiritual relationships.[2] Of course this is an interesting thought-provoking line of reasoning. However, this is not the direction we want to go. It is our intention to show how this model can be fruitfully applied in psychiatry and psychotherapy with regard to interpersonal relationships and the interwovenness of these relationships with spiritual relationships.

Agneta Schreurs (2002, 2006) was the first to apply Brümmer's approach to the study of the interface between psychotherapy and spirituality. We will show that the model enables us, as therapists, to give an account of the dynamics in these types of interpersonal and spiritual relationships. Each basic type of interpersonal and spiritual relationship can be examined as to which relational capacities are involved and are practiced. Within each type DoS receives a certain profile in terms of being related, sense of worth and sense of being restricted or growth. Each category can also be examined as to what are the immature and restrictive ways of constructing spiritual life. And, again, positive and negative possibilities of these types of relationships allow us to assess the potential for therapeutic change (For a summary of the characteristics see Table 1).

Table 1: Characteristics of the three basic types of the interpersonal and spiritual relationships

	Manipulative	*Contractual*	*Fellowship*
Relation	One-sided (I-it) impersonal	Two sided, conditional personal (I-You)	Two sided, non-conditional personal (I-You)
Differentiation of Self	Slave Submissive Inner independence	Employee Obedient Cooperation	Friend/son/daughter Love Reciprocity
Forgiveness	Punishment	Penance	Forgiveness as a gift

2 Although it is not claimed in our model, it could be interesting to investigate whether it would be maintainable to rephrase as "relationship between deity/deities or god/gods and humans/persons …". The root metaphors we introduce function as instruments for organising (relational, spiritual) experience (Schreurs, 2002, pp. 86-89). Maybe it is possible to extrapolate.

Three basic types of relationships

The impersonal or manipulative relationships

The key words for the first basic type of relationships are "impersonal" and "manipulative". It is impersonal in the sense that only one partner is his or her own agent. The other, although a person, is treated as if he or she were an object, a thing, a non-person. Therefore relationships such as these are called asymmetrical, because one partner (A) has complete control over the other partner (B). It does not mean a priori that such a relationship cannot be beneficent for the one under control, but the one in control treats the other as an object rather than a person. A forces or manipulates B. Such an impersonal relationship is not based on mutual positive feelings. Simply, because it is not possible to manipulate a commitment. Only free personal agents can commit themselves. Slavery can be seen as prototype of such a relationship. Also in incestuous relationships one of the partners is treated and manipulated as an object. Medical practice often runs the risk that patients have the feeling of being treated as objects. What do patients mean when they say they feel treated as number? In such a case the patient is or apparently just feels like the one out of many who needs to be cured, as an object, the one that needs to be operated on. For organizational reasons a patient number might be necessary, however *feeling* treated like a number makes it an impersonal encounter, which might have a negative impact on the working alliance; the patient could become frustrated, angry, and "mis-treated". It feels as though one's value is ignored.

In what aspects of religious or spiritual life do we recognize this type of impersonal spiritual relationships? If God's action is thought to be the direct cause of everything, then the human being is totally dependent on God for everything. Religious or spiritual convictions in this sense tend to be more or less deterministic. The divine being is the one in absolute control. Humans have no free choice either to accept or to reject whatever good or bad God allots to them. Another example of such a deterministic view would be belief in fate, which never, however hard we try, can be avoided. Prayer in this type of relationship is nothing more than a way to accept the inevitable, although that may contribute to inner peace, or may help the person to cope. Often the ones who are manipulated try to achieve the impossible, by trying to

manipulate the manipulator through magic rituals and related religious rites. On the other hand, using rituals within this relational context might contribute to a feeling of strength. In this way, we also see the importance of the connection with DoS, since the sense of being a respected, valued individual is a problematic issue in this type of relationships. DoS is an important marker of maturity. Maturity might be at stake in this type of relationships (Worthington & Sandage, 2016, pp. 89-90).

Not only from a theological point of view, but also from a psychology of religion and psychotherapeutic perspective deterministic world views and meaning systems such as certain communal and personal theologies are conducive to a problematic basic attitude of passivity, insecurity and fatalism. However, there are people who, despite the fact that they are not in a position to act as free and responsible persons, still have the inner freedom to choose a certain attitude and develop the qualities it requires. So the potential for change has to do with this notion of inner freedom. From a spiritual point of view it is possible to change an attitude of servitude towards willing obedience, or humility (Schreurs, 2006). Some people do indeed reach an impressive inner strength and peace in that way.

Brümmer (1992) paid special attention to the topic of forgiveness, which is an important issue from a diagnostic and therapeutic perspective as well. What does forgiveness look like in an impersonal type of relationship? Forgiveness, or seeking forgiveness, in this type of relationship is not really possible. If the object-partner is the offender, then the partner in control will decide what should be done, as the one responsible for whatever happens in the relationship, and will decide whether and how the relationship will be restored. And if the one in control is the offender, then the object-partner is usually manipulated or coerced into forgiving. Real and genuine forgiveness is only possible in personal relationships, which this first basic type of relationship is not.

Contractual (or mutual agreement) relationships

The second type is the category of mutual agreement or contractual human and spiritual relationships. According to Brümmer, this type is based on mutual agreement. Two persons accept certain rights and duties toward each other. Take, for example marriage. Ideally marriage is

based on mutual fellowship, but there is always an aspect of mutual agreement and obligation "for better or for worse".

In reality this applies to all three modes of relationships, they are always mixtures in which one of the three (often) is dominating. There is always the possibility that an impersonal feature is not completely excluded. In the Netherlands we have a saying about marriage: "her right is her sink unit" [haar *recht* is haar *aanrecht*]; these two words, right and sink unit, are in Dutch very similar and differ only by a prefix. In other words, we are talking about a categorization, a conceptual instrument, not a full description of concrete relationships. An actual relationship may be rather complex.

Mutual agreement is like the relationship between an employer and an employee. Such an agreement is about work and payment. People recognize the claims which they make on each other with a view to the advantage which each party can gain for the self. The agreements may be formal or informal. There is an enormous variety. However, the case is always that the goods or services which one partner receives from the other according to the agreement constitute an interest which the recipient could only realize by means of the agreement. Therefore in agreements of rights and duties the relationship has a certain instrumental value for me as a means for furthering my own interests. As such the partners are replaceable. Nevertheless, as distinct from impersonal relationships, both partners can be emotionally involved and commit themselves to act for the good of the other, they both benefit from it. Love may be a factor, but not necessarily so, not in a defining way. Marriages are not always entered for love. So loss of love does not automatically end this type of relationship. Good and fair fulfillment of the mutual obligations is decisive. In contrast to impersonal relationships, mutual agreements are symmetrical relationships. Partners freely decide to enter into them. Mutual agreements are not coercive, but they do create obligations. To put it in another way, I can buy, earn or merit your services, but not your fellowship or friendship or love.

In spiritual relationships of mutual agreement we also see that the relationship is a personal one. Both the Almighty and the human being, although fundamentally different, acknowledge each other as partners, and both partners are responsible to each other for continuity and quality of the relationship. The classical biblical concept is obviously the covenant and within that the place of the will of God and obedience

to that will. In the impersonal model, the human person is an object of the divine will, which is something that simply overcomes you, just that. In the model of contractual relationships things are different. The will of God is something to be done. Misfortune is something that overcomes you, and you might be angry or disappointed, but in case of misfortune the question remains how to do God's will in these circumstances; either from a sense of obligation as in agreement relationships, or from the heart as in love relationships. The main challenge with which such spiritual relationships confront people is that they encourage them to focus on performing the obligations of the agreement they are involved in. Usually this comes down to a focus on morality.

Prayer in this type of spiritual relationship is not a magic ritual, but a plea to oblige or to remind God of God's obligations to act in accordance to God's covenantal promises. It can also be a negotiation, a reaffirmation, or expression of gratitude for being partner in this relationship. Or even a protest because under the given circumstances obligations are too heavy to perform. Or an act of penitence because one failed one's obligations. As we see, this spiritual relationship is far richer than the first type, although it has not the depth of mutual love spiritual relationships.

The contractual type of relationship can often be observed in religions. People meet their obligations in order to receive the promised blessings. In theologies modeled after this kind of relationship freedom and responsibility are granted to both partners. People are not forced, but invited to share responsibilities. However, it is always possible that this freedom is misused. And then the damage must be repaired, or it could mean the end of the relationship. The covenant is the prototype of this relationship. Theologies such as these have been and are very influential, and are especially known for their satisfaction theology: Jesus Christ offered himself as a substitute to undergo the punishment humanity deserves for its sins, and in doing so has saved humanity from eternal damnation.[3]

3 The famous German philosopher Sloterdijk (2007) gives his analysis of what at first view appears as this second type of relationship. However, he speaks about a personal "Suprematismus" of a personal God, that makes the relationship asymmetrical. *Continued next page>>*

How does forgiveness function in a contractual type of relationship? The partners in this type of relationship assign each other freedom and responsibility, but they also know that they are in a sense dependent on the other for maintaining the relationship. In case of offence the matter is settled according to the principles of rights and duties. The one offended has the right to demand satisfaction by the offender, who did not fulfill the contracted promises and duties. In other words, the balance between rights and duties is broken and needs to be restored. This can be done in three ways: by satisfying the rights of the offended, by punishing the offender, or by waiving the rights to the duties by the offended.

Mutual love or fellowship relationships

In a relationship of mutual fellowship the partners choose to serve the interest of each other, not primarily their own. I not only recognize your interests, but I identify myself with you by treating your interests and your claims as my own. In that sense I love you as myself. I want your good, not merely as much as I want my own, but as being my own. Aristotle defined a friend as a "heteros autos", another self. This definition holds a certain ambiguity. "I remain different from you, but we are of one mind in wanting and hoping for those things that are good for you, and in fearing whatever is bad" (Brümmer, 1993, pp. 164-165; cf. Arreguín, 2010). Therefore the partner no longer has just an instrumental value. In relations of fellowship, where I identify with you and treat your interests as my own, your value and the value of our relationship becomes intrinsic for me. As such neither you nor our relationship can be replaced by another. Other relationships of fellowship with other people could also be rewarding and satisfying, but they are never the same since you, as the person who is the reason for having

That would be in our view more like the first type, the manipulative relationship. Sloterdijk does not make this differentiation. The main point Sloterdijk wants to make is that the more this "Suprematismus" is leading, all the more the believer will radicalize and extremism will be present. We can accept this important elaboration. However, Sloterdijk not only does not differentiate between the first and second type of relationships according to our model, he also does not seem to be aware of our third type (pp. 118-147; see also Jones, 2006).

the relationship, would be missing. You are you, and therefore unique (p. 165). These relationships play a very important role in our existence since we owe our value and identity as persons to such relations. Personal value and identity are bestowed on me by the fact that others love me and therefore consider me irreplaceable to them. That is what our self-esteem secures, and what gives body to our sense of identity. And of course for religious believers this applies especially to fellowship with God. The ultimate value of their very existence is bestowed on it by the fact that God loves them, and not merely their services.

Fellowship is not coercive. I do not further your interests because I am obliged to do so in order to merit your serving my interests in return. I cannot buy or merit your fellowship. Lovers give each other everything freely. Fellowship therefore is more risky, since there is much more at stake. My value as a person is at stake! If you refuse my fellowship you reject me. When valuing the other as a unique self I put myself personally at risk. I am involved as a person, not as an impersonal evaluator (Brümmer, 1993, p. 169). Bestowing love on the other is totally different from evaluation of the other. "Love *creates* value in its object, and does not merely *recognize* it" (p. 169). Our identity as persons is bestowed on us in the love which others have for us. However, the relation between love and person is also the other way round. Our identity is equally determined by the love we have for others. This does not mean that there are no obligations in love. Of course there are, but love goes beyond obligation (Wolterstorff, 2015, p. 43).

In spiritual relationships modeled in this way we see the same vulnerability of both partners, because neither can compel, cause or oblige the other to reciprocate. Surprisingly, God may be more vulnerable than we are because God keeps God's love and commitments, whereas we all too often breach or just forget ours. In other words, God puts Godself at risk of being wronged. It would be very strange from a relational point of view if this would not be the case (Wolterstorff, 2015). In such theologies salvation is not merely based on satisfaction, but on forgiveness. The partner who forgives pays the price for reconciliation, because that partner is willing to suffer the consequences of the wrong done to the self rather than lose the friend or beloved. In theologies based on this model the death of Christ is interpreted as revealing the extent of willingness of God to forgive.

Since partners in relationships of mutual love are freely committed to each other because the partners are precious for one another, prayer in spiritual mutual love relationships is opening up towards God. Both partners are unconditionally interested in each other's uniqueness and in the meaningfulness of the interaction.

What happens if a relationship of fellowship becomes damaged? How could a breach be healed? Forgiveness is quite different in this type of relationship. Fellowship can only be restored effectively if the offender, in identifying with the offended, is willing to seek forgiveness. Penitence is necessary but not sufficient. I cannot earn forgiveness, but I can express my desire to restore the relationship. Forgiveness is always a gift of the person who, although offended, is willing to forgive and willing to identify with me again despite the hurt. That willingness is rooted in the belief that the breach in our relationship is a greater evil than the injury (Brümmer, 1992, p. 441).

Change from this perspective is not primarily change of behavior. It has to do with learning receptivity, inwardness, trust, reverence, obedience, and especially the capacity to accept forgiveness and to forgive others, to give preference to suffering rather than breaking the relationship with the one who has injured or betrayed me as a person.

Spiritual relationships and personality dysfunction

Based on the foregoing explanation of the model we now want to take our second step. Before continuing, we must to introduce a few assumptions we take for granted in our discussion. In our view these assumptions are not unreasonable. In fact we have two. Firstly, there is always an analogy between spiritual and interpersonal relationships. We explained a model that offers root metaphors to assess and understand (the analogy between) these spiritual and interpersonal relationships. Secondly, there is growing interdisciplinary awareness, especially in psychology of religion, that a relational (contextual) approach of spirituality has the potential to pave a way forward (Augustyn et al., 2017).

How are we to connect these ideas about spiritual relationships with personal functioning and by extension with personality problems or disorders? Or, more broadly formulated, how to connect (theology

based) concepts, constructs and research findings in psychology of religion with model development in psychiatry? We would like to explore the following. Would it be possible to link our model with the levels of self and interpersonal functioning and self-other differentiation as proposed by the DSM-5™ in the so-called alternative model for personality disorders (APA, 2013; Porter & Risler, 2014) in combination with research and theoretical frameworks in the psychology of spirituality and religion?

The so-called "alternative model for personality disorders" in DSM-5™ offers a hybrid, mixed categorical-dimensional model in contrast to the traditional categorical, multiaxial model introduced in DSM-III. In this approach self and interpersonal functioning constitute personality functioning. Disturbances of self and interpersonal functioning are the core of personality psychopathology (Skodol, Bender, & Oldham, 2014). The main difference between the traditional DSM approach and the alternative model is that in the former it is a common research strategy to look for associations between certain personality disorder criteria and certain health and spirituality indices; this has been done by many including by ourselves (Schaap-Jonker, Eurelings-Bontekoe, Verhagen, & Zock, 2002). We found that the more personality pathology is present, the more negative the image of God. We also found that the association between symptomatology and image of God is mediated by personality pathology. In the alternative model it would still be appropriate to search for associations between indices of spirituality and pathological traits, but the approach of personality functioning creates the possibility of taking an interpersonal or relational view, and to connect with the newest developments in the research of psychology of religion.

The possibility to search for a connection between the DSM-5™ proposal and the relational approach in psychology of religion comes into the picture because according to the alternative model interpersonal (or relational) functioning is one of the two domains in which to assess the level of (impairment of) personality functioning.

Bypassing the whole discussion of categorical versus dimensional approaches, the latter is the core of the alternative model for personality disorders (cf., Pychodynamic Diagnostic Manual, PDM Task Force, 2006). Personality disorders in this alternative approach are defined by impairments in personality functioning and pathological person-

ality traits. We will concentrate on the level of personality functioning. How is this designed? Based on research it is stipulated that self and interpersonal functioning are at the core of personality functioning. Both aspects are described by two elements. Identity and self-direction as elements of self, and empathy and intimacy as elements of interpersonal functioning.

These four elements just mentioned turned out to be the most reliable out of a broad range of self-other constructs (Skodol, Bender, & Oldham, 2014, p. 514). It is striking that the designers of the alternative model seem to reckon that self and interpersonal functioning are closely related. They do not give the impression that the order, first identity and second relational functioning, is a matter of principle. We know, however, that autonomy is a prevailing value in the DSM tradition (Sadler, 2005). In our model the order is a matter of principle.

Nevertheless we see that the core of the alternative model concurs with what we called the consensus on relatedness. Or at least it can be said that empirically based constructs support the consensus, while the consensus enables us to put these empirical findings in a philosophically or theologically argued model. However, the DSM tradition strongly focuses on the individual and traits (on "selves and attributes of selves", Schreurs, 2002, p. 196). Mental disorders happen to individual people (Sadler, 2005, p. 178). The definition of a mental disorder in DSM-5™ was not changed on this point. Nevertheless, the dimensional definition of self and interpersonal functioning of the alternative model seems to be a little bit different. "Mental representations of the self and interpersonal relationships are reciprocally influential and inextricably tied, … underscoring the importance of assessing an individual's characteristic self-concept as well as views of other people and relationships" (APA, 2013, p. 772). Here we find a very clear accent on the basic connection between self and relationships, in other words: the relational self or self in relation. This concurs very strongly with our model, and with the way in which relational frameworks are subject of conceptualization and research in psychology of religion.

Let us have a closer look at identity as an element of self. It is defined in the following way: "Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience" (APA, 2013, p. 762). How does this look

compared to self- and other-regarding terms as we used them in our relational model? Obviously the sense of uniqueness is central, characterized by clear boundaries, sound self-esteem and self-appraisal and adequate emotion regulation (DoS!). Indeed, this uniqueness exists by the grace of the fact that personal value and identity, as experienced in sound self-esteem and self-appraisal, are bestowed on me in this type of personal and spiritual relationship. But also vice versa. Not just the value bestowed on us, but also the value we bestow on others determines our identity (Brümmer, 1993, p. 171). However, contrary to the value neutral formulation of DSM-5™, we introduced a value based model. Love is the core value. Anyway, with regard to our intended dialogue, if this similarity is sound enough then there is no need for conflict between psychiatry, psychotherapy, and (psychology of) religion/spirituality. Dialogue can start. Especially when we recall the topic of DoS. There is a strong resemblance between how differentiation of self is integrated in relational spirituality and how the self is operationalized in the alternative model of DSM-5™. With regard to our model, there is long tradition that differentiates the self between slave, mercenary and son as a typology of the partner and a mode of relating in the three types of relationships, based on a balance between anxiety and love.

Now we will have a closer look at intimacy as an element of the interpersonal domain. It is defined as "Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior" (APA, 2013, p. 762). How does this look compared to self- and other-regarding terms as we used them in our relational model? Depth and duration are paramount, together with closeness and mutuality of regard. We formulated love as a mutual form of identification, which of course never means that we become identical. I serve your interests as my own, I love you as myself, as you serve my interest as your own (Brümmer, 1993, p. 215). Again, there is always our distinct individuality and mutual acceptance of each other's individuality. How would we be able to take each other seriously otherwise, including our good and bad characteristics? Love does not make us blind. And of course, as Brümmer (1993) explains, it takes time and energy, as becomes visible in how we handle our desires, capacity for closeness and mutuality of regard (p. 218). It takes time and energy to know each other and to gain knowledge about each other. A

lot could be added, but it suffices to note that the resemblance in our view is not contrived. We demonstrated a clear basis for a dialogue on such essential aspects as relational and spiritual functioning (For a summary of the analogy see Figure 1).

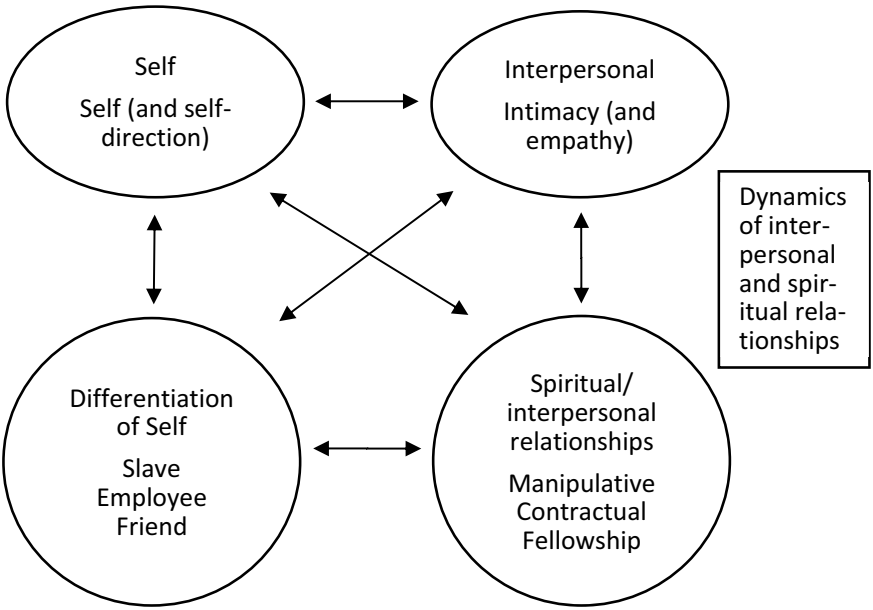

Figure 1. DSM-5™ Model of interpersonal and spiritual relationships—The analogy of spiritual relationships to interpersonal relationships.

Conclusion: Implications

We conclude our explanation of the model and proposal for dialogue with three implications: (a) clinical assessment of spiritual and interpersonal relationships, (b) dialogue among researchers, and (c) therapeutic and spiritual progress.

Much as in personal relationships between individuals, spiritual relationships are complex and unique. Yet it can be important for a therapist to assess whether and in what way a patient's spiritual relationship influences or is influenced by his or her functioning with regard to self and relatedness. The types of spiritual relatedness as well as

various combinations and modifications no doubt have great impact on how people find meaning and direction in their occasionally troublesome lives.

Therefore psychiatry and psychology of religion should start an interdisciplinary dialogue. The input of psychology of religion on relational frameworks is not only welcome, but also enriching. At the same time although it is stated that relational spirituality affects interpersonal relationships (and vice versa) empirical studies focus on narrow groups of participants and on narrow outcomes. As far as we know there is no (or very little) research among personality disordered patients and their spiritual and relational functioning. There is enough reason to develop a research focus on this. Instead of narrow outcomes, the focus should be broadened to what is called the promotion of human flourishing with regard to life domains such as meaning and purpose (e.g., spirituality) and relationships (spiritual and interpersonal).

In our comparison of the model we explained, utilizing the definitions of identity and intimacy of the DSM-5™ alternative model for personality disorders, that we concentrated on our third type of relationships. That does not mean that the two other types are necessarily disordered types. Our model is not a model only for disordered functioning. However, as a conceptual model it can help to understand both normal and pathological personality traits and facets in their relational and spiritual context by offering root metaphors. Clinical investigation of the structure and the dynamics of a spiritual relationship could be very helpful and inform the clinician about the existential, cognitive and relational aspects of a spiritual relationship: what does this relationship with that P(p)erson mean to the patient; what does the patient know about the P(p)artner, and what is happening between the two P(p)artners. Such an approach would obviously be more focused on the person of the patient.

Finally, therapeutic and spiritual progress have a lot in common. Both depend in a sense on nurturing one's ability to commit oneself to meaningful, honest and trusting relationships of fellowship. Equally so, defense mechanisms resisting change in one of these domains are likely to be present and contribute to resistance to change and progress in the other. Moreover, the capacities needed to give more depth and meaning to a personal relationship with God resemble the same capacities needed to foster and improve meaningful interpersonal relation-

ships. A preparedness to listen to the other, a willingness to express and share one's inner thoughts and feelings, awareness of each partner of the positive and negative factors operating in their interactions, a readiness to trust and be personally trustworthy, and being committed to change are all personal attributes that spiritual practice and therapeutic practice are designed to engender. Just as in psychotherapy clinging to another person for selfish reasons may change into perceiving and loving the other as the person that other is, in and for the other's self, so an ego-centered attitude towards God may change into loving God for who and what God is. Again, psychiatry (and psychotherapy) and psychology of religion should start to develop research strategies on this in order to promote better spiritual and relational functioning.

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Part III. Conclusion

Chapter 9

General discussion

This thesis is a compilation of ten published papers and two book chapters, presented in chronological order. These chapters began with leading questions with some subquestions: "What are the conceptual, theoretical and clinical concerns that need to be addressed in order to establish a (preferably) worldwide consensus on the relevance of religion (and spirituality) in psychiatry?" This was the overarching question. Subquestions were: "How can common ground be gained in the discussion? What are the controversies? What are the obstacles, theoretically, practically and in terms of professional policies? How can these controversies and obstacles be assessed, addressed and solved? And, of course, what should, ideally, be the content of the consensus?"

As far as I know there are no other papers published on these specific questions. Although the participants had many discussions at WPA international symposia, no WPA minutes or other documents are available.[1] There are only two WPA contributions that served to support the

1 The only formal documents are the questionnaires to evaluate the reinstatement of the Section, by which sections present: (a) a plan of action at the start of the term; (b) at least two symposia at WPA meetings in the three-year period between General Assemblies; (c) have carried out activities described in the proposed plan of work e.g. produced positions statements in their area of expertise, published materials supporting WPA educational programmes, carried out relevant research work; (d) have updated information on the website on activities and publications of the Section and its members; (e) have carried out activities described in its plan of work or presented valid reasons for not having done so and has presented financial reports as requested by the Executive Committee (WPA, 2017, pp. 13-14). *Continued next page>>*

aim of this thesis. The first one is the chapter written by Van Praag and Verhagen (2006) in a WPA volume. This volume was edited by the WPA secretary of sections, G. Christodoulou. This publication served as a discussion paper on behalf of the *WPA Section on Religion, Spirituality and Psychiatry*. It was circulated among colleagues around the world and sent to the *Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists* (Verhagen & Cook, 2011, p. 615). The second one is the edited WPA volume *Religion and Psychiatry. Beyond Boundaries* (Verhagen, Van Praag, López-Ibor, Cox, & Moussaoui, 2010). In the epilogue of that book we published the first version of a statement, drafted by Cook (Verhagen & Cook, 2010; see Chapter 6 Section 6.1). That draft version became the basis of the Royal College of Psychiatrists Position Statement on Spirituality and Religion (written by Cook, 2013) and finally of the WPA Position Statement (Moreira-Almeida et al., 2016; see Chapter 6, Section 6.4). A different type of contribution is the forum on the complex interplay between religion and mental health as it was published as a special section in the WPA journal *World Psychiatry* in 2013 (pp. 26-43; see Chapter 6, Section 6.3).

In other words, it was not possible to document WPA (internal) contributions, and therefore this thesis is not about WPA procedures or discussions. The exception is that WPA Sections are mandated to bring forward issues that require attention from psychiatry worldwide. That international and multi-religious context created the opportunity to discuss and reflect on themes that had occupied me in clinical practice for many years. This thesis has in fact become an intellectual justification of a lifelong fascination for psychiatry and religion, from the perspective of the clinician, within a worldwide community, culminating in a position statement and in a characterization of a reflective position toward psychiatry and religion. I call this reflective attitude a stance. With this stance I want to stay as close as possible to clinical practice. The latter is also the aim of the WPA Position Statement. I explain this in more detail below.

The immediate reason for all the work I did, and the resulting thesis, concerns clinical practice. The clinical question I focused on was, and

The WPA Section on Religion, Spirituality and Psychiatry submitted its first reinstatement questionnaire in 2007. The Section had fulfilled all requirements and had organized seven symposia in the three-year period.

still is, how to deal with religious issues in clinical practice: on what grounds and for what purposes? The current answer to these questions is that cultural (and religious) competence is a matter of professionalism. That is certainly an achievement. But even then the question remains of how psychiatrists can integrate this knowledge and expertise into their professional attitude. This calls for a broader, more reflective competence. In order to advance beyond the well-known controversies, it was necessary to broaden the scope, and seek to define the relationship between religion and science. In particular Sections 6.1 and 6.2 report on this search. How can our empirical and theoretical understanding of religion in science (and in psychiatry) correspond with a meaningful interpretation of the relationship between religion and science? This brings me back to the levels of observation and explanation model, that I presented in the General Introduction. That is my tool.

Four levels of observation and explanation

In the general introduction I argued that I probably would find a mixture of theories from various scientific orientations, and a multitude of empirical data, e.g. on religion and mental health indices or mental disorders, symptoms and traits, and correlations between aspects of them. I expected to find contradictions, conflicts, many being the same, as well as improvements, progress and growing awareness. Therefore, I formulated a framework based on a model with four levels of observation and explanation. I suggested a few basic viewpoints to orient myself in this apparent jumble of theories: (a) A reductionist perspective on theories; it was suggested that this perspective, although useful, is not sufficient to do justice to the full spectrum of possible relationships between psychiatry and religion; (b) A continuum perspective that proposes that, synchronically, phenomena at different levels of analysis and theories about these phenomena may be reducible but also irreducible to one another; (c) An even more pluralistic position that allows for both inter-level integration and (temporary) isolation of theories as possible positions, next to the reductionist and the continuum approach. With help of these three basic viewpoints I have a tool to examine inter-level relations.

"The devil is chasing me"

First, allow me to describe again the levels of the observation model with the help of a vignette. When I meet a patient in the consulting room, the patient tells his or her story on an everyday life level of experience (*first level*). At this level of understanding the patient talks about his or her complaints and symptoms. This story is, among others, determined by the cultural and religious or spiritual background of the person, and his or her idiosyncratic experiences. One finds constructs that the individual creates with regard to his or her identity, self and self-image, interpretations and justifications of what is going on, social, religious and/or spiritual dimensions of health and (mental) illness, and expectations with regard to therapy and recovery. In our vignette, the patient emotionally explains that it is the devil who is chasing her.

Then something happens. Something is done to the story that is told. The mental health professional reconstructs the story into a clinical case, a diagnosis, and a case formulation (*second level*). The case formulation elaborates on the identified disorder, the patterns that are discerned in the story of the patient, the social context and the clinician-patient relationship, from a categorical description and classification to a personalized perspective, which furthermore leads to therapeutic action. What happens to the patient's story about the devil chasing her? Probably the clinician has tried to discern among signs of psychopathology (psychosis? mood disorder? anxiety disorder?), an anomalous experience (spirit possession?) or another kind of authentic or pathological religious experience; after all, there is more between heaven and earth than we have dreamt of (Rashed, 2018). Or the clinician has tried to distinguish between a symptom of a disorder and coping with the disorder or how the patient relates to the disorder (e.g., her statement on the devil as an expression of demoralization, or as a peculiar form of intentionality, as Rashed explains the phenomenon of spirit possession).

One possible course of events could be that the psychiatrist discovers inconsistencies in the patient's religious story about herself. These inconsistencies could lead to inappropriate or harmful thoughts and/or actions with respect to herself and/or others. These thoughts and actions could point to psychopathology, but not necessarily so. What knowledge would a clinician require in order to be able to reach

a conclusion, both about psychopathology and about the possible harm? This obviously raises a series of new questions.

One of these questions could be a search for scientific evidence. What is known about the impact of possibly harmful beliefs on the incidence, occurrence, clinical picture and course of psychiatric symptoms and syndromes? This *third level* refers to the scientific perspective. On this level a clinical question or problem is interpreted or (re)formulated in scientific or research language. In the case of religion and psychiatry disciplines such as neuroscience, psychology of religion, social psychology and theology are involved in the analysis of affective, cognitive, interpersonal and spiritual processes or dynamics. However, based on their experience with empirical research in medicine and psychiatry or in psychology of religion psychiatrists are all acquainted with the difficulties in translating the clinical material into a scientific discourse, and back again to the everyday experience of the patient.

A very interesting example of such an interdisciplinary analysis and dialogue on a paranormal phenomenon is the case study by Lomax, Kripal, & Pargament (2011). A psychotherapist (Lomax), a historian of religions (Kripal) and a psychologist of religion (Pargament) discuss a special moment in a psychotherapy session. In a very moving way the patient describes a meaningful paranormal experience. The experts discuss the experience on the basis of four key words: the paranormal, the sacred, the psychical, and the telepathic. And this is exactly what a multilevel multidisciplinary dialogue could look like. Insights from history of religions, from psychotherapy research, and from psychology of religion are brought together in a clarifying way, which ultimately benefits the therapy process in which the client is involved. Therefore, it is a pity that such case studies are rare, because "the types of interdisciplinary dialogues and discussions that led to this article will expand the therapeutic repertoire of clinicians to the benefit of patients and lead to a more positive anticipation of psychotherapeutic help by the general public" (Lomax et al., 2011, p. 17).

The *fourth level* is the philosophical or meta-theoretical level. On this level we describe the basic premises of theoretical models e.g., the bio-psycho-social-spiritual model (De Haan, 2017; Verhagen, 2017), a stress-vulnerability model in medicine and psychology (Braam, 1999), or an explanatory pluralism model for psychiatric illness (Kendler,

2008, 2012) in psychiatry and adjacent disciplines. The same holds true for every scientific discipline, e.g., scientific theology, irrespective of religious tradition. For example, in philosophical theology propositions and concepts of religious doctrines are elucidated and extended by using standard philosophical means of analysis and argument. It could be asked whether the sentence about the devil chasing somebody has meaning and, if so, what this meaning is. This is a theological question. Another more philosophical question could be in what way psychiatry is able to integrate a view on evil, asking in what sense illness is related to evil or not. Or is it the other way around? Has psychiatry and its view on psychiatric disorder changed our view on evil (Stone, 2010), for instance, by seeing religion as a biological adaptation from an evolutionary perspective, and fear of supernatural beings as a necessary step in making us human (Johnson, 2016). That would inevitably bring us to a discussion about the cognitive study of religion and neuroscience; and to the question what kind of religion this "neurobiological" religion is. Is that still the religion that is lived, the spirituality that is experienced? There is a certain resemblance to what has happened to morality, as Schirmann (2014) has described: "(…) the neuroscience of morality is altering what it seeks to study" (p. 32). It means that the application of cognitive science in studying religion is never a neutral act. The same applies to evidence-based psychiatry as I have shown. Of course, there is a neurobiological perspective on any human experience, but the historical and psychological perspectives are still "alive" and all these, and other, perspectives must fulfill the criteria of internal and external consistency and coherence.

Inter-level dynamics: Chapter 5 according to the four levels

Would it be possible to place my findings in the model of levels of observation and explanation? An example of this is the line of reasoning in Chapter 5. The intention of that paper was to illustrate the improvements of empirical research into religion in psychiatry, despite still existing contoversies. I looked at four meta-analytic reviews over a period of 45 years. However, unlike King (2014), I related my findings to ethical questions concerning evidence-based psychiatry, its gold standard, and the possible impact of the evidence-based medicine paradigm

on the understanding of religion. The result appeared to be surprising. Religion turned out to be one of the many aspects of life "that are good for your health". That is not necessarily wrong, but it is at best a facet of religion, and not its most important, from a theological point of view. For instance, in Christianity it is said that cure of illness is not the first aim but victory over illness, of which cure is a promising sign.

This example from my own work illustrates the strategy of empirical research, based on abstraction from daily experience, within the methods of evidence-based psychiatry. This takes places on and between levels 2 (clinical level) and 3 (scientific level), see Fig. 1 (see also Ellens, 2017; Larzelere, 1980). According to evidence-based methodology, therefore, these two levels interact very strongly with each other. Research methods have their strengths and weaknesses, which call for improvements and more sophisticated methods to come as close as possible to daily experience and to be able to explain causality, which is still a difficult problem (Dein, Cook, & Koenig, 2012). The relevance of outcome measures should be made explicit in every new clinical context. And the results of scientific research have to be interpreted. And this requires, as I demonstrated, that both personal and contextual factors must be taken into account. However, there is more to say.

Given the degree of abstraction, the interaction with level 1 is less strong. This abstraction in the form of operationalization is necessary, but vulnerable, because one makes a transition from subjective experience to objectification. That is not wrong, but the question is what is lost when religious experience is pulled out of the context in which it occurred? Here I refer only to Flournoy's classical principle of the exclusion of the transcendent, according to which researchers should neither reject nor affirm the independent existence of the religious object (Wulff, 1991, p. 25). It is said that this lies outside the domain of their competence. Psychology of religion is concerned with the "*feeling* of transcendence" (Wulff, 1991, p. 25). Formulated this way, the principle suggests a kind of neutrality toward the religious truth claim. Rizzuto gives a typical example of this neutrality position in her view on psychoanalytic psychotherapy of religious patients (Rizzuto, 1996, pp. 415-419). What is the relationship between the God representation and God as a "postulated transcendent being"? This relationship is constituted by the representation. Representations are the means the mind has to know any reality. Psychoanalytic psychotherapy is

concerned with these representations, not so much with the reality behind them (Rizzuto, 1996, p. 417). However, this neutrality is itself not neutral. By not answering the question of whether something is lost, when transcendence, or belief in transcendence, is put between brackets, it is suggested that the answer on this question does not matter, at least not for the scientific or clinical understanding of what is going on. But, is this neutrality inevitable? Is it not possible to modify one's concept of (God) representation by saying that "something really external and objectively of God (has) been taken inward" (according to Spero, quoted by Rizzuto, 1996, p. 418; see also Spero, 2010). One could assume that this transcendence evokes its own dynamics, for instance from a theistic point of view on divine-human dynamics (Pleizier, 2010, pp. 57-60). Of course, these questions cannot be resolved between levels 2 and 3. The topic of transcendence also indicates level 4 (see also Drees, 2010; Glas, 2007; Jones, 1996, pp. 140-150; see also López-Ibor & López-Ibor Alcocer, 2010).

What is suggested here is that if the transcendent yields its own input, this will lead to a different account of (God) representation. According to the model of four levels and inter-level dynamics, one could defend the position that research that is based on the principle of exclusion of the transcendent as reality, and that these two approaches are still isolated from each other. This position can then be interpreted, not as an end point, but instead as a moment in an ongoing debate that helps to keep the discussion open and to improve our level of scientific understanding.

What about the interactions with level four? Gupta (2014) put me on the track of ethical questions regarding the traditional evidence-based-medicine approach (especially Chapter 6 "The ethics of evidence-based medicine", pp. 117-148). There is more to this approach than empirical methodology alone. Gupta asked to which ethical values and to which ethical theory evidence-based medicine is committed (see Chapter 5). I added theology (religion) and asked what the impact is of the ethics of evidence-based medicine on the understanding of religion. I asked also how this ethical dimension impacts on the understanding of religion and how this understanding is connected with the development of cultural values according to the values maps. These new questions not only go back to methodology (level 3) but also to operationalization (level 2) and to reflection on daily, religious

experience (level 1). I particularly addressed the question of the impact of the ethics of evidence-based medicine on our understanding of religion, because, clearly, the evidence-based research method is not value-neutral. And indeed, I noticed a bias that I otherwise would not have detected so easily and certainly would not have connected with the impact of empirical research on values that pertain to the field of inquiry. The bias I am referring to concerns the tendency to define religion in terms of its health benefits: Religion is good and something to aspire and make use of if it improves health. This bias is reflected in the analysis of values according to the World and European Values maps. It is probably needless to say that most of the time religion on the level of daily experience is not just a matter of achieving health. And there is no inner necessity to limit the concept of religion to this aspect in religious studies (level 3) and philosophy (level 4).

In my view these elements make the picture more complex, but also more realistic. In Figure 1 I try to visualize the multi-level model of observation and understanding. The left column shows the four levels. The middle column is meant to indicate interdisciplinarity. Every level is connected with a range of scientific disciplines: Science 1, science 2 to science n. The right column shows the inter-level interactions.

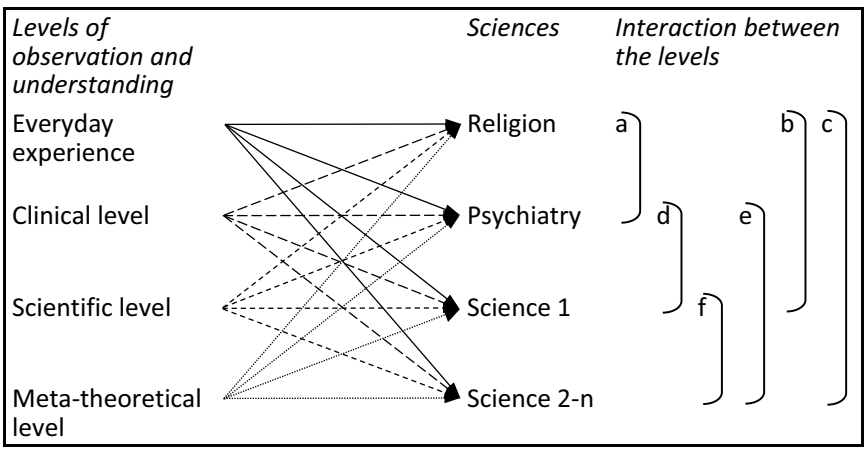

Figure 1. P&R Stance: The plurality of practices of "psychiatry and religion" as sets of disciplines.

The arrows in the figure point at the relationships between each level and the other levels, suggesting that, as I said previously, "theories at different levels of description can co-evolve, and mutually influence each other, without the higher level theory being replaced by, or reduced to, the lower-level one" (p. 7). For instance: the issue exclusion or inclusion of the transcendent is a meta-theoretical question with implications at a scientific, clinical and everyday level of understanding. And the other way around: What does belief in the transcendent imply for clinical assessment and research, the scientific study of religion and meta-theoretical fieldwork?

A clinical issue such as demoralization may serve as an example. Having a mental disorder is not just a matter of having that disorder (clinical level). The disorder has an impact on the patient's relationship to that disorder, and the patient relates to the disorder in his or her unique way (daily experience). This all happens within a certain medical and cultural context. Is demoralization then a symptom of the disorder? Or is it (also) an expression of how the patient deals with that disorder? Is it an expression of his or her personality make-up? Is it connected with a form of negative or positive religious coping? Demoralization is, therefore, an example of a multi-layered concept, and is to be investigated on more than one level (see also Glas, 2017, pp. 536-537).

The same applies to other concepts that have passed in this thesis. In Section 6.1 I followed the idea that religion and science are allies against superstition and nonsense. The strength of the multi-level approach is that it makes the allies aware of the possibility to investigate concepts like superstition and nonsense in a differentiated way in order to overcome misunderstandings and controversies and to reach for consensus.

The brackets indicate the inter-level interactions. It is also possible to differentiate between strong and weak relationships. By strong I mean that great value is attached to it, besides awareness of and consensus about the approach. By weak I mean the opposite, less value, less awareness, less consensus. There are strong relationships between the operationalizing of religion and clinical empirical research within an evidence-based approach (brackets a and d). These relationships are strong in the sense of our basic viewpoints: the theories co-evolve and influence each other, progress is made and that is needed

and promising. However, the relationship between daily experience and the operationalization of religion is mixed: strong in terms of the empirical approach, but less strong when it comes to the quality of the operationalization (level 1). The following question remains: to what extent is the experience done justice to in the operationalization? Different approaches exist next to each other, and co-evolution is possible.

The relationships with the meta-theoretical level are also weak (brackets e and f), since there is not much interdisciplinary interaction between the disciplines mentioned. I made an initial attempt in Chapters 5 and 8.

If it is reasonable to regard this complexity in this way, it throws a different light on the controversies. It is not a matter of contradiction or exclusion as such, but theories can co-exist and co-evolve, even if they are contradictory.

There is a plurality of views, based on a plurality of findings and perspectives. The data are the same but their meaning is interpreted differently by different researchers and clinicians given their different schools of training and life orientations. This plurality leads inevitably to the necessity of making personal choices, embedded within the social practices that science and religion are (Stenmark, 2004). What can be said about this personal matter? Is it a matter of attitude?

Three desiderata

I want to conclude with three desiderata based on this thesis. I would like to argue for: (a) The promotion of interdisciplinary dialogue and collaboration; (b) A religion and psychiatry stance as a personal and collective position in that interdisciplinary dialogue and collaboration; (c) The epistemic obligation to try one's utmost best to reach for truth. Finally I will pose – what I call – a "Hilbert problem".

Interdisciplinary dialogue

There is much to be said about religion (and spirituality) and the interface with psychiatry (and psychotherapy). It is a field of inquiry and clinical practice that is multifaceted and multilayered. In order to grasp all these facets and layers it seems self-evident to look for what is called a *multilevel interdisciplinary paradigm*, as the psychologists of religion

Emmons and Paloutzian have repeatedly proposed (Paloutzian & Park, 2005, 2013), or even an interdisciplinary-relational approach aiming at a "relational integration" of psychology and Christian theology, as has been suggested by the theologian LeRon Shults and the psychologist Sandage (LeRon Shults & Sandage, 2006; see also Sandage & Brown, 2018; Welker, 2012).

Several models for integration have been proposed. Balboni, Puchalski, and Peteet (2014) introduced an approach on a clinical practice level. They broadened the scope to medicine as a whole and proposed three complementary models: a whole-person approach, an existential approach, and an open pluralism view. The main issue in these three approaches is not just that spiritual and existential concerns are taken into account, but also that these concerns serve as focal points for intervention. The authors explain that each model offers a view on the professional role of the clinician depending on its context. And interestingly, despite the differences in opinion among the authors, they agree on an inclusive view on religion and spirituality, not-religious, secular and cultural views included. They agree on the importance of ethical reflection, professional training and collaboration with spiritual care professionals (Balboni et al., 2014, p. 1596; see also Glas, 2009a, b,c, 2018).

Since in all these multidisciplinary approaches of psychology of religion and spirituality mental (and physical) health and psychopathology are important components, psychiatry also should participate in the dialogue. Such a dialogue and collaboration between psychiatrists, psychologists of religion, and colleagues in neuroscience, cognitive science, philosophy, theology, ethics, and history, is essential for future research and for the improvement of clinical practice and assessment of patients and the disorders they present. Human flourishing and mental health interdisciplinary work should be promoted, not only regarding mental illness and disorders, but also with regard to religion (and spirituality) as a determining factor for personal and social well-being (Schotanus-Dijkstra, Ten Have, Lamers, De Graaf, & Bohlmeijer, 2016; VanderWeele, 2017).

Obviously, one of the main concerns behind the recommendations of the Position Statement is the urgency for this interdisciplinary dialogue.

Stance and certainties

As I wrote in the General introduction, I found myself thinking about fundamental attitudes and started wondering whether it would be possible to formulate a position with respect to the relationship between psychiatry and religion, especially from a clinical point of view, that would help to open previously closed views. The debate and scientific work, including this thesis, does not take place in a vacuum. On the contrary. The debate on psychiatry and religion cannot be restricted to its theoretical construction based on clinical practice and empirical research. This restriction is useful, but also inevitably leads to reduction. Religion is, for instance, defined as a set or list of characteristics or dimensions. There are several of such lists and there is consensus on four components: belief, practice, awareness and experience. This consensus even exists between opponents such as King and Koenig (2009).

Despite this consensus, controversies remain at a deeper level. They emerge in various ways: in the interpretation of empirical results and the assessment of their relevance for clinical practice, in the way clinicians appropriate the empirical evidence that is currently available, and in the cultural appreciation of religion. With respect to this cultural appreciation, what we are witnessing today is not only a "psychologisation" but also a "neurobiologisation" of religion and of our understanding of ourselves. One of the new branches in science of religion is known as the cognitive science of religion. With respect to this science, the old questions return: What is religion? How can it be studied? What is the relevance of scientific findings for our everyday and theological understanding of religion and of mental phenomena? Some defenders present the results of the new science as "culture-free, ideologically free factual knowledge on life as it is" (De Vos, 2016, p. 233). Keeping in mind what was said above about different positions in the science-religion debate, this seems a questionable personal position in the debate.

I propose to consider the approach that has been chosen here as a "stance". This stance–at a minimum–entails a pluralistic, reflective approach to the intersections between psychiatric and religious phenomena, intersections that are studied from different levels of understanding. However, there is more to having a stance than the study of intersections between phenomena that differ in kind and the analysis of the different ways of knowing these phenomena and their intersections. So

how do I define a stance? The American philosopher Van Fraassen (2002) coined the concept: "A philosophical position can consist in a stance attitude, commitment, approach, a cluster of such–possibly including some propositional attitudes such as beliefs as well). Such a stance can of course be expressed, and may involve or presuppose some beliefs as well, but cannot be simply be equated with beliefs or making assertions about what there is" (pp. 47-48). In other words, a stance is not just a belief or opinion, although beliefs and opinions are part of it. It is a combination of attitudes, a certain way of reasoning, of doing research and of acting. I use it as a collective term for a set of related commitments, certainties, goals, attitudes and concerns, that are guiding and unified in a coherent whole, involving "a (…) *self-regarding commitment for its own preservation*" (italics by Van Fraassen, 2004, p. 177).

To go into this more deeply, to work it out a bit further, doing something, such as doing science or clinical practice or practising religion, presupposes a set of what Mühling calls certainties (Mühling, 2014, p. 14; see also Mühling, 2012). What are certainties within this context? Certainties are a specific kind of pragmatic knowledge. Mühling (2014) gives the example of writing a book (p. 14). If I want to write a book, I have to know what the book is about, how to write, how to use research facilities, and that it is meaningful to write this book. Probably some of these beliefs are not very explicit, but nevertheless, one thinks about it, one becomes aware of these and probably other beliefs or certainties. Certainties such as these are always there. They are not securities, they are not infallible, and one can question them. According to Mühling (2014), certainties are not hypotheses either. The practice of science and theology may aim at the development of and search for hypotheses, but the practice itself presupposes certainties. "Therefore, whereas hypotheses provide the advantage that potential actions only imply potential consequences no one is actually responsible for (because they are only potential, not actual), actual actions imply certainties that do imply real consequences–they alter the state of the world we live in–and are therefore my responsibility (….) Certainties are always a serious matter, whereas hypotheses only stand to become serious." (p. 15).

Two examples of certainties are the following. In clinical practice there is a certainty about how to perform a clinical interview, how to make contact, and how to address various topics including religion.

Religious history taking is therefore a consequence of a "religion and psychiatry stance" in so far as religion is taken as a phenomenon in its own right, i.e., as potentially reflecting a person's deepest commitments and concerns. The recommendations of the Position Statement are consequences of such a stance. They include an element of practical wisdom, based not only on scientific knowledge but also on values, competencies, and worldviews within a reflective attitude. Certainties in science concern, for instance, conventions with regard to the gathering and evaluation of evidence as it is practised in evidence-based psychiatry. Again, including religion as a phenomenon in its own right is a realistic consequence of a religion and psychiatry stance.

Certainties have an action-guiding meaning. Most of the time, we are probably not aware of our certainties, since they are undisputed or self-evident. Nevertheless, it can be useful to make them explicit, for instance in the dialogue between science and theology, and between psychiatry and religion. Of course, as Mühling (2014) explains, certainties are bound to persons, hypotheses are less bound in that sense. Does that mean that certainties are merely subjective? No, it does not. Certainties are particular, but they do not fall from the sky. They are connected with professional and/or cultural habits and traditions (p. 16). Nobody is without tradition. Tradition can be considered as the objective aspect of certainties (Markus, 2004, p. 149). Heuristically, certainties have three aspects: they are guiding, subjective and objective; think again of Mühling's example of writing a book.

A final important element must be mentioned. What do these considerations mean for the dialogue between science and religion? It can only mean that certainties always influence the work of the scientist and the professional, thus, in two directions. Implicitly, non-empirical certainties shape the attitude, the work and the goals of the scientist and professional. As Mühling states (2014), this shaping happens all the time (p. 25). On the other hand, scientific findings and discoveries also re-shape the certainties and commitments of the scientist and the professional (p. 25). In fact they can have huge effects, causing not just minor changes but ground-breaking changes as well. For instance, consider the impact of evolution theory and psychoanalysis on the understanding and explanation of religion. This bidirectional impact brings Mühling to the conclusion that "every interdisciplinary dialogue always implies an inter-religious dialogue" (p. 26). To formulate it a bit

broader: every interdisciplinary dialogue always implies a dialogue between worldviews.

This is fully recognized in the recommendations of the Position Statement, not only on a scientific level, but especially on the clinical level, in a positive way, for the benefit of the patient, but also in a cautionary way to protect the patient.

Epistemic virtue: Critical reflection

The plurality, as we stated previously, leads to the need to make personal choices, embedded within the social practices that science and religion are (Stenmark, 2004). To repeat the questions I posed: What can be said about this personal matter? Is it a matter of attitude? To whom do I actually ask that question? To the philosopher, to the scientist, to the clinician? It depends on the context, but within an interdisciplinary dialogue it concerns them all. Therefore I want to point at the issue of critical reflection in connection with the stance I described. My contention would be to think of the cultivation of epistemic or intellectual virtues in view of critical reflection (Peels, 2017; Pouivet, 2002; Waring, 2016). Epistemic or intellectual virtue is nothing less than to try one's utmost best to reach for truth. Waring and Peels list a number of traits of epistemic conscientiousness as a disposition: open-mindedness, intellectual sobriety, courage, precision, diligence, perseverance and thoroughness. Peels adds a few vices as well: epistemic conformity, laziness and self-indulgence (Peels, 2017, p. 92). He characterizes epistemic virtues (and vices) as belief-influencing factors, by which he means "that whether they are actualized or not makes a difference to whether or not we believe a proposition *p*" (Peels, 2017, p. 91). Both authors emphasize that having a disposition does not mean that one does not have to cultivate such a disposition, because having does not guarantee acting according to what one is disposed to (Peels, 2017, p. 93). Pouivet (2002) points at another aspect. Theoretical thought compels "mental segregation". One is forced to split one's mental life in favour of reason and at the cost of imagination; an unwanted dichotomy, certainly when it comes to religion. Virtue epistemology calls for (mental) wholeness. So there is an intellectual, epistemic obligation for critical reflection.

Although it is not specifically stated, I would argue that the success of the recommendations of the Position Statement can only work with this epistemic obligation.

To conclude with: "Hilbert problem"

In 2015 the editors of *Religion, Brain & Behavior* invited scholars to submit "what they take to be the most pressing Hilbert problem in the study of religion" (Bulbulia, Wildman, Sosis, & Spezio, 2015, p. 264). They received 30 submissions, of which 17 were published (Sosis, Wildman, Bulbulia, & Schjoedt, 2017, p. 274). David Hilbert (1862-1943) was a famous mathematician who posed ten unsolved mathematical questions in 1900 at an international conference in Paris. These were core questions for the future (Bulbulia, 2015, p. 263). What should a scientific discipline understand better? What is really fundamental? What might reconfigure the field of inquiry? The editors wanted to formulate Hilbert problems especially for the study of religion, even beyond the scope of *Religion, Brain & Behavior*. Based on this thesis, I would propose the following very simple, but simultaneously complex, Hilbert problem for the study of religion in psychiatry, indeed beyond the scope of religion, brain and behavior: How can scholars with their very diverse religious, spiritual, philosophical backgrounds–given their creative and fruitful views, insights, certainties and motivations–be saved from jumping to conclusions and taking argumentative shortcuts? That is to say, how can professionals scientifically identify what they suspect as religious issues at all levels of observation?

Let us look again to Fig. 1. Bracket (a) refers to the interaction between daily experience, colloquial language, subjectivity and cultural context, in short: the whole person, and clinical practice, history taking, assessment, diagnosis, in short: the person and his illness. I call this inter-level interaction *understanding*, in a sense it is still pre-scientific. Bracket (a) is related to (b) and (d) – in short daily experience and clinical practice seen by a scientific discipline relevant to psychiatry, and vice versa, the scientific discipline seen from daily experience and clinical practice. I call this inter-level interaction *interpretation* in the light of scientific theories. Brackets (c), (e), and (f) relate to the meta-

theoretical level. I call this inter-level interaction *critical reflection* in the sense of meta-theoretical fieldwork.

These three inter-level interactions refer to the fact that not only empirical data are involved, but also beliefs, values, rules for understanding, interpretation and for critical reflection, and non-evidentiary considerations. In other words, the solution for the Hilbert problem at the end of this thesis has to be found in the methodical evaluation of these inter-level interactions that are always present in any research that scholars do to the best of their knowledge.

It is the claim of this thesis that I have provided a framework that makes room to examine this question in its full breadth and depth.

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Addendum

Summary

This thesis concerns two closely related themes: psychiatry and religion. A dialogue between psychiatry and religion remains difficult to conduct despite the awareness that religion (and spirituality) can play an important role in the way patients cope with their mental disorder. The main question in this thesis is therefore whether it would be possible to achieve a consensus on the relevance of religion (and spirituality) in psychiatry in the WPA worldwide community? What are the controversies, what would a consensus look like?

The interconnectedness between psychiatry and religion was elaborated in a consensus document, as accepted by the *Executive Committee* of the World Psychiatric Association (WPA; 2015). The consensus document was developed and presented to the WPA by the *Section of Religion, Spirituality and Psychiatry*, co-founded by the author, in collaboration with the *Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists* (London, UK).

In this thesis I first define the research theme in Chapter 1. I outline the essential contours of the study and then provided by a brief overview of the study. In order to be able to get some grip on the content I introduced a "four levels of observation and understanding model", which we return to in the general discussion. The thesis is about psychiatry and religion and not about the one and the other separately. Nevertheless, to define the starting point, I cannot avoid giving a brief characterization of each of the two.

Part I of the thesis focuses on the controversies and consists of a brief introduction and three chapters that were previously published. In Chapter 2, the reader is informed about the founding, goals and work agenda of the WPA Section on Religion, Spirituality and Psychiatry. This outlines the context of the work done, and also indicates the epistemic, practical, collective and individual goals typical of social practices like psychiatry and religion.

Chapter 3 characterizes the attitude of psychiatrists toward the relationship between psychiatry and religion, which is more or less tra-

ditional, critical, indifferent or undecided, but rarely positive. The chapter also shows that this attitude contradicts findings based on extensive scientific evidence and indicates what should be expected as a result. This evidence has revealed a largely positive relationship between religiosity/spirituality and various indices of health. Despite the attitude of psychiatrists in general, the neglect of this fact is difficult to justify. However, religious and spiritual beliefs are powerful forces and may impart harmful as well as beneficial effects.

Whatever disagreements there might be on definition and use, spirituality and religion are concerned with the core beliefs, values and experiences of human beings. A consideration of their relevance should, therefore, be a permanent part of clinical and academic practice in psychiatry.

The objective of the review in Chapter 4 is based on three assumptions: (a) Religious or spiritual well-being is an important aspect of health (including mental health); (b) Empirical evidence has revealed a largely positive relationship between religiosity/spirituality and various indices of health; (c) Psychiatrists should be expected to respect and be sensitive to the spiritual/religious beliefs and practices of their patients at all time, and not to use their professional position for proselytizing or undermining faith. Three aspects are reviewed in Chapter 4. In the first part I explore the impact of modernization on religion and the culture in the Western world. With the help of data from the "World Values Surveys" it is possible to acquire a picture of the existential, psycho-cultural world of Western people. In the second part, I evaluate the outcome of empirical research that has been done regarding the relationship between religion (and spirituality) and indices of mental health. Meta-analyses on this topic have shown predominantly positive correlations, but also mixed and negative results. The third part involves a further elaboration on the professional attitude of psychiatrists. The lively debate on the practice of religious history taking is discussed in some detail. The overall conclusion of the chapter is that I found enough evidence to support my assumptions, and that psychiatrists should cast off their distrust and acknowledge that it is a matter of professional practice to include religion and spirituality in patient care.

Chapter 5 starts with the outcome of a substantial body of empirical research indicating a positive correlation between religion, spirituality

and mental health. This outcome requires some explanation. Between 1969 and 2013, the quality of the research improved considerably, as is shown by four consecutive meta-analyses from that period. However, the researchers deliberately or not adapted their research strategies to the evidence-based paradigm as the golden scientific standard. This has consequences, also for the view that people have in regard to religion. How could religion become one of the effective tools for achieving health? A critical analysis shows that utilitarianism is the ethical basis of the evidence-based approach in medicine and achieving health is its central value. As a result, religion acquires a different meaning with a strong emphasis on the experiential-expressive aspects. That fits in perfectly with modern Western values, as was shown in chapter 4.

Based on the above, four scenarios on the future impact of research on religion and spirituality and on mental health are presented at the end of Part I.

In Part II, the consensus process is addressed, consisting of a short introduction followed by three chapters based on six articles that were previously published.

In Chapter 6, four short articles are combined. The first three articles were actually intended to continue the discussion after what had happened in 2008. A draft consensus document had been worked on for some time, but at the last minute this version was not submitted to the General Assembly of the WPA. The text was published afterwards and is republished here (Section 6.1). The fourth contribution includes the text of the WPA Position Statement, accepted in 2015 and published in 2016.

The objective of Section 6.1 is to reflect on the significance of the discussions on religion and science for the World Psychiatric Association (WPA). At the time this chapter was completed, reflection on this topic had not even begun, despite the publication of the WPA handbook *Religion and psychiatry: Beyond boundaries*. In accordance with the model proposed by the Dutch philosopher of religion Willem Drees, two statements are formulated and discussed:

1. The WPA, which represents world psychiatry, must change its position toward religion and spirituality. It should do so by

eliminating narrow-minded scientific boundaries like reductionist and materialistic boundaries.
2. Psychiatry and religion should not be regarded as opposing adversaries, but as allies against nonsense and superstition.

The boundary between religion (and spirituality) and the practice of psychiatry is becoming increasingly porous. In a multi-faith, multi-cultural, globalized world, psychiatrists can no longer dismiss religious belief as pathological, or hide behind biomedical scientism. Consequently, there is a far more important reason for engaging in "Religion and Science" than the outdated conflicts: the persistence of religious and scientific superstition and nonsense.

In Section 6.2 it is stated that although there is still a lot of controversy surrounding the debates on religion and psychiatry, working toward consensus based on clinical experience and research seems to be far more fruitful.

The main reasoning runs as follows. It is no longer appropriate to treat psychiatry and religion as enemies: they are in fact allies. This position is elucidated in the light of the two statements, previously introduced in Section 6.1. Two recommendations are formulated. First, science-and-religion, and in our case psychiatry-and-religion is not purely about description based on gathering evidence, systematic empirical testing and mathematical modelling. We need an approach involving both descriptive and prescriptive aspects of our daily reality: not only how our world is, but also how it should be. Second, science-and-religion, in our case psychiatry-and-religion as allies, should formulate sensible criteria and develop an appropriate, discerning attitude based on intellectual, moral and spiritual sincerity.

In Section 6.3, I call for a consensus based on four of the five criteria that the WPA has formulated. These four criteria are: relevance, scientific evidence, the public interest, and damage that the absence of a consensus could bring with it. The five criteria are discussed in more detail in Chapter 7.

The final text of the Position Statement is presented in Section 6.4. A translation is provided at the end of the summary in Dutch.

In December 2015 the Executive Committee of the World Psychiatry Association (WPA) accepted a Position Statement on Spirituality and Religion in Psychiatry. In Chapter 7 I briefly sketch the background of

the development of this Position Statement, the criteria it needs to fulfill, the aim of the published position Statement, and some desiderata with regard to its future. An interesting side effect is that the editors of the journal in which Chapter 6 was published, *Mental Health, Religion and Culture*, decided to create a special issue on the occasion of the publication of my article (Chapter 7) on the Position Statement to allow the dialogue to continue (2017, 20[6], pp. 513-602; Verhagen, 2017).[1]

The purpose of Chapter 8 is to contribute to the dialogue on spirituality in mental health care (psychiatry and psychotherapy). Spirituality is still an uncomfortable topic in mental health care despite the burgeoning research and publication on this theme. I introduce a conceptual model on spiritual and interpersonal relationships based on love in relatedness. I argue that this model will enable (psycho)therapists to assess the interconnectedness of spiritual and interpersonal relationships, analyze the positive or negative effects of spirituality on interpersonal functioning (and the reverse), and look for possibilities for spiritual and therapeutic change. Based on the model, the next step is to reflect on the relationship between psychiatry and spirituality with a view to dialogue instead of unfruitful discussion and controversy. I propose a dialogue on the alternative DSM-5™ model for personality disorders. The common ground with the model and the DSM-5™ model consists of the elements of personality functioning: the self and the interpersonal functioning. Although the results are preliminary, I show the usefulness of such an interdisciplinary dialogue.

I conclude with a General discussion, Chapter 9. I come back to the levels of observation and explanation model, and use the model to analyze the content of this thesis, especially Chapter 5 as an example. This is followed by three remarks, or better desiderata. The approach should help to promote interdisciplinary dialogue and collaboration. In such a dialogue and collaboration a stance in favor of "psychiatry and religion" is needed. I do not posit the connection between psychiatry and

1 Verhagen, P.J. (2017). Spirituality and religion in psychiatry: In dialogue with the World Psychiatric Association Position Statement [Editorial]. *Mental Health, Religion & Culture, 20*(6), 513-515. doi:10.1080/13674676.2017.1389108

religion as a scientific (empirical) hypothesis, although there is a great deal of (empirical) scientific work available that supports the interrelatedness of psychiatry and religion (positive, negative or indifferent), and not as a religious position, but as a professional attitude, an approach, a stance, characterized by the epistemic obligation to do one's utmost best to reach for truth. Finally I have posed a "Hilbert problem": How can scholars with their very diverse religious, spiritual, philosophical backgrounds, or stances, given their creative and fruitful views, insights, certainties and motivations be saved from jumping to conclusions and argumentative shortcuts? That is to say, how can professionals really scientifically map what they suspect as religious issues at all levels of observation? I use the levels of observation and understanding model again, especially the inter-level interactions, to point in the direction of a possible solution with three keywords: understanding, interpretation and critical reflection.

Samenvatting (summary in Dutch)

Dit proefschrift gaat om twee thema's die nauw, zij het ook problematisch, met elkaar verbonden zijn: psychiatrie en religie. Een dialoog tussen psychiatrie en religie is nog altijd niet eenvoudig te voeren ondanks het feit dat het besef wel is gegroeid dat religie (en spiritualiteit) een belangrijke rol kunnen spelen in hoe patiënten omgaan met hun mentale stoornis en de lasten die zo'n stoornis met zich mee kan brengen. De centrale vraag in dit proefschrift is of het mogelijk is een consensus te bereiken over het belang van religie (en spiritualiteit) in de psychiatrie in de wereldwijde gemeenschap van de World Psychiatric Association (WPA)? Wat zijn de controversen? Hoe zou zo'n consensus eruit kunnen zien? De verbondenheid tussen psychiatrie en religie is uitgewerkt in een consensus document, zoals dat aanvaard is door de *Executive Committee* van de World Psychiatric Association (WPA). Dit consensus document is in feite een concretisering met aanbevelingen voor de wetenschappelijke en klinische praktijk van de psychiatrie. Het document werd ontwikkeld en aangeboden aan de WPA door de *Section on Religion, Spirituality and Psychiatry*, waarvan auteur dezes mede oprichter is geweest, in samenwerking met de *Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists* (London, UK).

In hoofdstuk een, de algemene inleiding, wordt het thema voor dit proefschrift uiteengezet, gevolgd door een overzicht van de inhoud. Om op voorhand wat grip op het materiaal te krijgen introduceren we een model met vier niveaus van analyse en begrip, waar we in de afsluitende discussie op terugkomen. Dit proefschrift gaat niet over religie en psychiatrie afzonderlijk. Toch ontkom ik er niet aan kort aan te geven wat ik onder religie en psychiatrie denk te verstaan.

Deel I stelt de controverse centraal en bestaat uit een korte inleiding en drie hoofdstukken, die eerder als artikelen werden gepubliceerd. In hoofdstuk 2 wordt de lezer geïnformeerd over de oprichting, doelen en werkagenda van de WPA Section on Religion, Spirituality and Psychiatry. Daarmee wordt de context van het werk geschetst, en wordt tevens aangegeven wat de epistemische, praktische, collectieve en individuele

doelen zijn, typerend voor de sociale praktijken van psychiatrie en religie.

Hoofdstuk 3 heeft als doel de min of meer traditionele, kritische of indifferente houding van psychiaters ten aanzien van religie en spiritualiteit te typeren en duidelijk te maken dat deze houding in schril contrast staat met wat op grond van uitgebreid wetenschappelijk onderzoek naar voren gebracht kan worden en verwacht zou mogen worden. De evidentie wijst op een positieve correlatie tussen religie/spiritualiteit en diverse indicatoren voor geestelijke gezondheid. De houding van psychiaters valt dan ook moeilijk te rechtvaardigen. Dat laat onverlet dat religieuze en spirituele overtuigingen niet alleen positieve maar ook schadelijke effecten kunnen hebben. Echter, welke verschillen van inzicht er ook zijn met betrekking tot definities en toepassingen, religie en spiritualiteit betreffen de kernovertuigingen, waarden en ervaringen van mensen. Het onderzoeken van de betekenis daarvan zou vast onderdeel moeten zijn in de klinische praktijk van de psychiatrie.

In hoofdstuk 4 wordt de controverse verder uitgewerkt. Drie aspecten passeren de revue. Er wordt stilgestaan bij de invloed van de moderniteit op religie en cultuur in de Westerse wereld. Met behulp van de zogenaamde *World Values Surveys* is het heel goed mogelijk een beeld te krijgen van wat heet de existentiële, psychoculturele wereld van de Westerse mens. Vervolgens wordt stilgestaan bij de uitkomst van empirisch onderzoek als het gaat over de relatie tussen religie en indicatoren voor geestelijke gezondheid. Er zijn meta-analyses beschikbaar die naast overwegend positieve correlaties, ook gemengde en negatieve uitkomsten laten zien. Het derde aspect betreft een verdere uitwerking van de professionele attitude van de psychiater. Daarbij komt een levendige discussie over de zogenaamde religieuze anamnese uitgebreid aan bod. De algehele conclusie luidt dat psychiaters hun afkeer zouden moeten afschudden en erkennen dat het een kwestie van professionaliteit is om aandacht te hebben voor religie en spiritualiteit in het leven van hun patiënten.

Hoofdstuk 5 vertrekt weliswaar bij de uitkomst van veel empirisch onderzoek dat zegt dat er een positieve correlatie is tussen religie, spiritualiteit en geestelijke gezondheid, maar hoezeer ook waar, dat vraagt wel om enige toelichting. In de periode 1969 -2013 is de kwaliteit van het onderzoek aanzienlijk verbeterd, zoals aan de hand van

vier meta-analyses uit die periode getoond wordt. Alleen, de onderzoekers hebben al dan niet bewust zich aangepast aan het evidence based paradigma als gouden wetenschappelijke standaard. Dat heeft echter consequenties, ook voor de opvatting die men huldigt over religie of de rol die men religie toedicht. Hoe kon religie één van de effectieve hulpmiddelen om gezondheid te bereiken worden? Een kritische analyse leert dat utilitarisme de ethische basis is van de evidence-based benadering in de geneeskunde en bereiken van gezondheid is de centrale waarde. Als gevolg daarvan krijgt religie een andere inhoud met een sterk accent op de experiëntiële-expressieve aspecten. Dat past op zich helemaal bij moderne Westerse waarden, zoals we in hoofdstuk drie hebben gezien.

Op basis van dit alles formuleren we aan het slot van het eerste deel een viertal scenario's voor de toekomstige impact van onderzoek naar religie en spiritualiteit en geestelijke gezondheid.

In deel II wordt de consensus naar voren gebracht. Het deel bestaat uit een korte inleiding gevolgd door drie hoofdstukken, gebaseerd op zes artikelen die eerder werden gepubliceerd (vier korte bijdragen zijn samengebracht in hoofdstuk 6). In een korte introductie wordt stilgestaan bij het feit dat er geruime tijd gewerkt is aan een ontwerp voor een consensus document, maar dat deze versie in 2008 ter elfder ure toch niet werd aangeboden aan de "General Assembly" van de WPA. De tekst werd nadien wel gepubliceerd en wordt hier opnieuw opgenomen.

Hoofdstuk 6 bestaat uit vier korte bijdragen waarvan drie bedoeld zijn als een reflectie op de betekenis van de discussie over religie en wetenschap voor de World Psychiatric Association. De vierde bijdrage is de definitieve tekst van het "Position Statement" zoals die door de "Executive Committee" van de WPA in 2015 werd aanvaard en in 2016 werd gepubliceerd.

In paragraaf 6.1 wordt de reflectie uitgedaagd aan de hand van twee stellingen:

1. De WPA die de wereldwijde psychiatrie vertegenwoordigt moet zijn positie ten aanzien van psychiatrie en religie wijzigen om daarmee voorbij te komen aan beperkende wetenschappelijke grenzen zoals reductionisme en materialisme.

2. Psychiatrie en religie zouden niet langer opgevat moeten worden als opponenten maar als bondgenoten tegen bijgeloof en (wetenschappelijke) nonsens.

Inmiddels begint de grens tussen religie (en spiritualiteit) en de psychiatrisch praktijk wat poreuzer te worden. Psychiaters kunnen zich in een multi-religieuze, multi-culturele en geglobaliseerde wereld niet langer verschuilen achter de opvatting als zou religie pathologisch zijn, of achter een biomedisch sciëntisme. Het is veel nuttiger deel te nemen aan de discussie religie en wetenschap, dan in ouderwetse conflicten te blijven hangen, met risico's naar beide zijden: bijgeloof en nonsens.

In paragraaf 6.2 wordt de redenering aan de hand van de twee uitgangspunten vervolgd: werken naar een consensus is veel vruchtbaarder dan vasthouden aan de controverse.

Er worden twee aanbevelingen geformuleerd:

1. Wetenschap en religie, in ons geval psychiatrie en religie, is niet louter een kwestie van descriptie, empirisch onderzoek en mathematische modellen. We hebben niet alleen te maken met descriptie maar ook met prescriptie van onze dagelijkse werkelijkheid, niet alleen hoe de wereld is, maar ook hoe (we zouden willen dat) ze zou moeten zijn.
2. Wetenschap en religie, in ons geval psychiatrie en religie, als bondgenoten zouden verstandige criteria moeten formuleren en een adequaat vermogen om te kunnen onderscheiden op basis van intellectuele, morele en spirituele oprechtheid.

In paragraaf 6.3 wordt gepleit voor een consensus op basis van vier van de vijf criteria die de WPA daar zelf voor heeft opgesteld: relevantie, wetenschappelijke evidentie, het publieke belang, en schade die het ontbreken van een consensus met zich mee zou kunnen brengen. De criteria werden in hoofdstuk zes uitvoeriger besproken.

De definitieve tekst van het Position Statement wordt in paragraaf 6.4 voorgelegd. Aan het eind van deze samenvatting is een vertaling gegeven.

In hoofdstuk 7 wordt teruggekeken op het hele proces en wordt het eindresultaat tegen het licht gehouden. De achtergrond van het hele proces wordt geschetst, de criteria voor een consensus document worden besproken en enkele desiderata met het oog op de toekomst worden geformuleerd. Een belangwekkende bijkomstigheid is dat de

redactie van het tijdschrift waarin hoofdstuk 7 als artikel werd gepubliceerd, namelijk *Mental Health, Religion & Culture*, die publicatie aangreep om een themanummer te maken en het gesprek over het "Position Statement" verder te voeren (2017, 20(6), pp. 513-602).[1]

Hoofdstuk 8 is een poging om bij te dragen aan de dialoog over religie, spiritualiteit en geestelijke gezondheid in de psychiatrie en psychotherapie. Het mag dan nog altijd een ongemakkelijk thema zijn, de dialoog gaat verder. Het hoofdstuk draait om een conceptueel model over spirituele en interpersoonlijke relaties. Relationaliteit is de ontologische basis van ons menszijn en liefde is daarvan de vervulling. Het model stelt de therapeut in staat om spirituele en interpersoonlijke relaties in hun wisselwerking te onderzoeken op positieve en negatieve aspecten over en weer, en te zoeken naar mogelijkheden voor verandering. De volgende stap is minstens zo belangrijk. We gaan op basis van het model de dialoog aan met het alternatief DSM-5 model voor persoonlijkheidsstoornissen. De raakvlakken met het model liggen bij de elementen van het persoonlijkheidsfunctioneren: het zelf en het interpersoonlijk functioneren. Ook al is deze dialoog niet meer dan een eerste aanzet, het toont het nut en de bruikbaarheid van zo'n interdisciplinaire dialoog als het gaat om religie en spiritualiteit in de psychiatrie.

Deel 3 is met hoofdstuk 9 de afsluiting met een discussie over de gevolgde route en methode. We komen terug op het schema van de niveaus van analyse en gebruiken het schema om bij wijze van voorbeeld hoofdstuk 5 te analyseren en om daarmee de bruikbaarheid van het schema als hulpmiddel te toetsen. Vervolgens formuleer ik drie wensen voor een goed vervolg. In de eerste plaats hoop ik dat de benadering in interdisciplinaire dialoog en samenwerking bevordert. In zo'n dialoog neemt men een bepaalde positie in, die ik aanduid als een psychiatrie en religie "stance". Ik poneer de relatie tussen psychiatrie en religie niet als een wetenschappelijke (empirische) hypothese, al is er heel veel (empirisch) wetenschappelijk werk beschikbaar dat de

1 Verhagen, P.J. (2017). Spirituality and religion in psychiatry: In dialogue with the World Psychiatric Association Position Statement [Editorial]. *Mental Health, Religion & Culture, 20*(6), 513-515. doi:10.1080/13674676.2017.1389108

hypothese over die (positieve, negatieve, indifferente) verbondenheid ondersteunt, maar als een houding, een benadering, een zogenaamde "stance", die niet zozeer een religieuze positie is als wel een professionele houding ten aanzien van religie en onder meer te karakteriseren is met een epistemische verplichting het uiterste te doen in het streven naar waarheid.

Ik eindig met een zogenaamd *Hilbert probleem*: Hoe kunnen wetenschappers met hun uiteenlopende religieuze, spirituele, levensbeschouwelijke achtergrond en houdingen, gegeven hun creatieve en vruchtbare visies, inzichten, overtuigingen en motieven bewaard blijven voor benaderingen en verklaringen die al te kort door de bocht zijn en voor argumentatieve (al te) snel(le-)koppelingen? Anders gezegd: hoe kunnen professionals werkelijk op wetenschappelijk betrouwbare wijze in kaart brengen wat naar hun vermoeden religieus materiaal is, en dan op alle niveaus van analyse? Ik kom dan nogmaals terug op het schema van de niveaus van analyse en begrip om kijkend naar de interactie tussen de vier niveaus een mogelijke oplossingsrichting van het Hilbert probleem aan te duiden met drie trefwoorden: begrijpen, interpreteren en kritische reflectie.

Vertaling van het WPA Position Statement (translation of the WPA Position Statement in Dutch)

Spiritualiteit en religie in de psychiatrie[1]

De World Psychiatric Association (WPA) en de World Health Organisation (WHO) zetten zich er voor in dat de bevordering van psychische gezondheid en geestelijke gezondheidszorg een wetenschappelijke basis heeft, en tegelijkertijd voldoende getuigt van compassie en culturele sensitiviteit. In de laatste decennia neemt het publieke en academische besef toe dat spiritualiteit en religie van belang zijn voor gezondheidskwesties. In systematische reviews van de wetenschappelijke literatuur komen meer dan 3000 empirische studies aan de orde over de relatie tussen religie / spiritualiteit (R/S) en gezondheid.

Met betrekking tot het domein van psychische stoornissen is er aangetoond dat R/S een significante invloed heeft op de prevalenties (van met name stemmingsstoornissen en verslavingsproblematiek), op de diagnostiek (zoals het onderscheid tussen spirituele ervaringen en psychische stoornissen), op de behandeling (zoals hulpzoekend gedrag, compliance, mindfulness, en alternatieve geneeswijzen), op uitkomstmaten (bijvoorbeeld herstel, of suïcide), op preventie, alsook op kwaliteit van leven en op welzijn. De WHO heeft R/S opgenomen als een dimensie van kwaliteit van leven. Hoewel er aanwijzingen bestaan dat R/S normaal gesproken is gerelateerd aan betere gezondheidsuitkomsten, kan R/S ook leiden tot schade (bijvoorbeeld weigering van behandeling, intolerantie, negatieve religieuze coping). Survey onderzoek heeft aangetoond dat religieuze en spirituele waarden, geloofsovertuigingen en gewoontes en gebruiken van belang blijven voor de meerderheid van de wereldbevolking; ook toont onderzoek aan dat

1 Deze vertaling is tot stand gekomen in samenwerking met en met dank aan prof. dr. A.W. Braam, lid van het huidige bestuur van de WPA Section on Religion, Spirituality and Psychiatry.

patiënten het op prijs stellen als hun vragen op het gebied van R/S in zorgcontacten aan bod komen.

Psychiaters dienen alle factoren te onderkennen die van invloed zijn op geestelijke gezondheid. Het beschikbare onderzoek maakt duidelijk dat R/S ook tot deze factoren is te rekenen, ongeacht de spirituele, religieuze, levensbeschouwelijke en filosofische achtergrond van de psychiater zelf. Niettemin beschikken maar weinig geneeskundeopleidingen of specialistische opleidingsprogramma's over een officieel scholingsaanbod voor psychiaters om nadere kennis te verkrijgen over de wetenschappelijke evidentie en over de geëigende manieren om R/S zowel wetenschappelijk als in de klinische praktijk te benaderen. Om dit gemis te ondervangen heeft de WPA, zoals ook plaatsvond in diverse landelijke vakverenigingen voor psychiatrie (zoals in Brazilië, India, Zuid-Afrika, het Verenigd Koninkrijk en de Verenigde Staten), een sectie opgericht met betrekking tot R/S. De WPA heeft religie en spiritualiteit als een vast onderdeel aangemerkt voor het "Core Training Curriculum for Psychiatry".

Voor geen van beide termen, religie en spiritualiteit, bestaat een algemeen aanvaarde definitie. Definities van spiritualiteit verwijzen meestal naar een menselijke ervaringsdimensie die gerelateerd is aan het transcendente, het heilige, of aan een ultieme werkelijkheid. Spiritualiteit is nauw verbonden met waarden, zingeving en het doel van het leven. Spiritualiteit kan zich zowel individueel ontwikkelen, als in gemeenschappen of tradities. Religie wordt vaak gezien als het institutionele aspect van spiritualiteit, doorgaans meer gedefinieerd in termen als geloofsopvattingen en geloofspraktijken, die betrekking hebben op het heilige of goddelijke, zoals gedragen door een gemeenschap of sociale groep.

Ongeacht al dan niet nauwkeurige definities gaan spiritualiteit en religie over de kern van geloofsopvattingen, waarden en ervaringen van de mens. De klinische en academische psychiatrie doet er goed aan om te reflecteren op hoe R/S van belang is voor het ontstaan, het begrijpen en de behandeling van psychische stoornissen, alsook voor de houding van de patiënt tegenover ziekte. Spirituele en religieuze overwegingen kunnen daarnaast belangrijke ethische implicaties hebben voor de klinisch psychiatrische praktijk.

In het bijzonder stelt de WPA voor:

1. Bij elke patiënt te overwegen om op een tactvolle en overwogen manier religieus geloof en praktijk, als ook spiritualiteit aan de orde te laten komen, hetgeen in sommige gevallen een onmisbaar element zal zijn van de psychiatrische anamnese;
2. Aandacht er voor te houden dat begrip van religie en spiritualiteit en hun verband met de diagnose, etiologie en behandeling van psychische stoornissen wezenlijk onderdeel uitmaken van de opleiding tot psychiater en van de professionele ontwikkeling en nascholing;
3. Te onderkennen dat er behoefte bestaat aan meer onderzoek over zowel religie als spiritualiteit in de psychiatrie, met name ten aanzien van klinische toepassingen. Dergelijk onderzoek dient te voorzien in een ruime culturele en geografische diversiteit;
4. Te onderkennen dat de benadering ten aanzien van religie en spiritualiteit persoonsgericht dient te zijn. Psychiaters dienen de eigen professionele positie niet te gebruiken om te bekeren tot een spirituele, levensbeschouwelijke of juist seculiere kijk op het leven. Van psychiaters mag altijd verwacht worden dat zij zich respectvol en sensitief opstellen ten aanzien van de spirituele en religieuze geloofsopvattingen en geloofsgebruiken van hun patienten, alsook van de familieleden en andere directbetrokkenen bij patiënten;
5. Dat psychiaters, ongeacht hun persoonlijke overtuigingen, bereid zijn om samen te werken met geestelijk verzorgers, pastores, andere geestelijk leiders en leden van geloofsgenootschappen ten behoeve van het welbevinden van hun patiënten. Ook is het gepast als psychiaters in multidisciplinair verband hun collega's tot deze samenwerking stimuleren;
6. Dat psychiaters laten merken dat zij zich er van bewust zijn en er ook respect en sensitiviteit voor hebben dat spiritualiteit en religie voor veel stafleden en vrijwilligers in belangrijke mate kunnen bijdragen aan het ontwikkelen van een roeping in hun werk in de geestelijke gezondheidszorg;
7. Dat psychiaters oog dienen te houden voor de mogelijkheid dat religieuze, spirituele en seculiere overtuigen en de bijbehorende

gewoontes zowel gunstige als schadelijke elementen kunnen herbergen. Psychiaters dienen bereid te zijn de kennis hierover op een kritische maar onpartijdige manier uit te wisselen met de samenleving in bredere zin ten behoeve van de bevordering van gezondheid en welbevinden.

Acknowledgements

I want to express my gratitude to many colleagues around the world who are committed for various reasons to the topic of this book. First of all I want to acknowledge the help of my two supervisors Rien van Uden and Gerrit Glas, who kept me focused on the initial purpose throughout this academic project.

Many others accompanied me during the past years. To start with, the founding board of the WPA Section on Religion, Spirituality and Psychiatry: Herman van Praag, founding chair, and Driss Moussaoui, founding co-chair. At the same time the founding of the Section was welcomed by WPA leadership and supported by Ahmed Okasha (WPA president, 2002-2005), Helen Herrman (then WPA secretary for scientific publications, nowadays WPA president, 2017), John Cox (then WPA secretary general, 2002-2008, later on co-chair of the Section), and the late, unforgettable Juan J. López-Ibor Jr. (1941-2015; WPA president, 1999-2001), who took the initiative to organize the international symposium *Psychiatry and religious experience* (Ávila, Spain, 2010), a collaboration between the López-Ibor Foundation and the WPA Section on Religion, Spirituality and Psychiatry.

I thank the current board of the Section, especially its chair, my successor, Alexander Moreira-Almeida.

Other WPA officials and colleagues, who feel strongly connected to the work of the WPA, also supported the work of the Section: George N. Christodoulou (then WPA Secretary for sections), Eliot Sorel, Roy Kallivayalil (current WPA Secretary general), Afzal Javed (current WPA president-elect), Dinesh Bhugra (WPA president, 2014-2017), R. Srinivasa Murthy, Ahmad Mohit, Nahla Nagy (former co-chair of the Section), María Inés López-Ibor Alcocer, John Peteet, Marc Hermans, C. Robert Cloninger, Samuel Pfeifer, René Hefti, Olga Borisova.

The collaboration with the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists has been of special importance, personified by Chris Cook, Simon Dein and Andrew Sims.

Among many Dutch colleagues, I mention the names of Arthur Hegger, Harold van Megen, Arjan Braam, Jaap van Belzen. I thank the

editors and the members of the editorial board of the unique Dutch journal *Psyche & Geloof* [Psyche & Faith].

Some of the names mentioned also refer to co-authorship. I want to add to these the name of Agneta Schreurs. She supported my project with her interest and her wisdom over the years. I also want to mention Hendrika Vande Kemp. With her rich expertise she helped me to improve the text in various ways.

My wife and I have shared mutual love and profound friendship for many years now. She supported me throughout this project and allowed me the time whenever and wherever necessary. I am very grateful to her. And we both are rich with the love and support of our children.

I have been inspired by many others, based on various resources. One of these resources is the new interfaith spirituality as proposed by Schmidt-Leukel (p. 131). We live in a religiously plural world. What should our attitude be? From what source should our attitude be refreshed? Schmidt-Leukel listed seven virtues for interfaith spirituality, with gratitude as the seventh. Gratitude is what I feel after completing this endeavor while working together with so many others.

Dankwoord (acknowledgements in Dutch)

De wording van dit proefschrift kent een lange geschiedenis. Ik ben ongeveer dertig jaar bezig geweest met het ontwikkelen van een idee. Ik begon bij Oskar Pfister, ik wilde me in deze o zo markante figuur verdiepen; misschien omdat ik in hem, oppervlakkig, een dubbelheid meende te zien of zocht, die ik in mezelf gewaar was. Het werd me even deskundig als resoluut door Jaap van Belzen afgeraden, omdat elders al iemand bezig was en weldra met een grondig werk over Pfister zou komen (Nase, 1993)[1]. Ik richtte me op het klinisch werk en geïnteresseerd als ik was in het psychoanalytisch werk van Erik H. Erikson meende ik parallellen en dwarsverbanden te zien tussen zijn ontwikkelingsmodel en dat van James W. Fowler en te onzent Robert Abraham. Het bleek te complex, althans voor mij, terwijl ik toch van mening ben dat het een heel interessante insteek had en zou kunnen zijn. Ondertussen raakte ik aan het begin van deze eeuw door toedoen van Herman van Praag, met wie ik als student in de collegezaal al discussieerde over religie in de psychiatrie, verzeild in de kringen van de World Psychiatric Association (WPA). Samen met hem en Driss Moussaoui (Casablanca, Marokko) richtten we de WPA Section on Religion, Spirituality and Psychiatry op; niet zonder impact mag ik ondertussen zeggen. In feite is dit proefschrift de neerslag van mijn activiteit als secretaris en nadien als voorzitter van deze WPA Section en ben ik wat dat betreft de "founding chair" en "founding co-chair" beiden veel dank verschuldigd.

Dat mag allemaal waar zijn, maar dan nog. Wat beweegt me om na mijn zestigste nog te kunnen promoveren? Laat ik eerst zeggen wie me bewogen. Dan moet ik natuurlijk, vooral en met groot plezier mijn hooggeleerde, meer nog hoog gewaardeerde promotores noemen. Beiden, Rien van Uden en Gerrit Glas, hebben bij herhaling er op

1 Nase, E. (1993). *Oskar Pfisters analytische Seelsorge. Theorie und Praxis des ersten Pastoralpsychologen dargestellt an zwei Fallstudien* [Oskar Pfister's analytical pastoral care. Theory and praxis of the first pastoral psychologist presented in two case studies]. Berlin: Walter de Gruyter.

aangedrongen er nu toch eindelijk iets van te maken. Materiaal genoeg, heette het. En zij hielden vol en hadden er klaarblijkelijk ook vertrouwen in. Dat is mooi, en dat het vervolgens toch nog enige tijd duurde ligt geheel aan mij.

Voor zover ik mijzelf wetenschapper noem, ben ik niet een empirisch wetenschapper, noch een origineel denker, zoals mijn beide promotores dat wel zijn. Ik ben vooral compilator, om zo te zeggen, en breng mensen en materiaal bij elkaar, zoals in de WPA Section; zo heb ik veel plezier en voldoening aan het werken en samenstellen van handboeken, themanummers en symposia. In die zin is dit proefschrift ook een compilatie. Is dat nuttig, zelfs wetenschappelijk? Dat denk ik toch wel. De verwachting is toch dat zo'n compilatie tot nieuwe gezichtspunten leidt. Misschien niet het meest origineel, maar ik vergelijk het, eenvoudig gezegd, met het schudden van een kaartspel. Deze keer heb ik de (meer of minder bekende) kaarten geschud, en komen ze op mijn manier te liggen. En dat is toch net weer even anders dan anders, ook al omdat ik naar aanleiding van dat schudden hier en daar toch ook voorstel de spelregels bij te stellen. En dat heeft wel degelijk consequenties, althans als we overeenstemming kunnen krijgen over die voorstellen. Anders gezegd, men is niet compilator zonder wetenschappelijke pretentie.

De beide promotores ben ik veel dank verschuldigd. Van Uden dank ik hartelijk voor zijn niet aflatende interesse, aandrang en ordening. "Het moet er toch een keer van komen"; op een moment waarop ik het wel zo'n beetje terzijde had gelegd, maar niet helemaal. Vooral voor zijn geduldige bereidheid om deze psychiater richting een finish te leiden, sterker nog, hem over die finish te krijgen, zal me bij blijven. Bovendien ben ik hem dankbaar dat hij het mij vergunt dat dit boek opgenomen wordt in de *International Series in Mental Health and Religion*, een serie die onder zijn hoofdredactie in 2014 van start ging.

Ietsje sterker wellicht is de geestverwantschap met Glas, met wie ik al jaren het grote voorrecht heb in allerlei verband te mogen samenwerken. Dat dit proefschrift mede een vrucht is van die samenwerking doet hem, naar ik hoop, deugd.

Dit proefschrift is maar een detail in hun beider werkzaamheid om religie, psychiatrie en geestelijke (volks)gezondheid onder de aandacht te brengen, met veel resultaat. Het academische landschap ziet

er daardoor op dit aandachtsgebied anders uit dan nog niet zo heel lang geleden. Dat is hun beider bijzondere verdienste!

De leden van de leescommissie ben ik zeer erkentelijk voor hun betrokken bijdrage aan de afronding van dit project. Zij hebben ieder in hun wetenschappelijk werk bijgedragen aan het thema van dit proefschrift en aan de psychiatrie in het algemeen. Ik heb veel van hun werk kunnen lezen en dat heeft zeker ook bijgedragen aan wat ik heb geschreven. Dat Simon Dein uit Engeland wilde overkomen om aan de finale deel te nemen lijkt natuurlijk eenvoudig te regelen, maar beschouw ik toch vooral als een voorrecht.

Ik dank Peter van Harten en Harold van Megen, die net als ik werkzaam zijn bij het grote GGz Centraal. Van Harten, in zijn hoedanigheid als directeur van het onderzoeksinstituut Innova, heeft mijn activiteiten altijd met interesse en waardering gevolgd, ook al stonden ze nogal los van de onderzoeksprogramma's binnen het instituut. En waar mogelijk stelde hij enige middelen ter beschikking, bijvoorbeeld om mijn Nederlands Engels om te doen vormen tot meer Engels Engels. Van Megen is zonder enige twijfel een sparring partner, zoals ik me niet beter kan wensen: betrokken, deskundig, relativerend, komisch en principieel, katholiek. Ik kan niet nalaten te zeggen dat die verbondenheid en gemeenschappelijke interesse leidde tot de redactie van het Nederlandstalige handboek over psychiatrie, religie en spiritualiteit, en dat ik hoop dat die verbondenheid leidt tot nog meer interessante projecten, niet in de laatste plaats ten behoeve van de opleiding tot psychiater.

De raad van bestuur van GGz Centraal en de directie van de resultaatverantwoordelijke zorgeenheid Veluwe & Veluwe Vallei dank ik voor hun bijdrage om de uitgave dit boek mede mogelijk te maken.

Op welke gronden kiest men paranimfen? Beide paranimfen hebben sterke Vlaamse wortels, en die zou ik volgens de genealogie ook nog hebben. Behalve dat ons dat tot een sterk team zou kunnen maken is dat toch niet zo'n doorslaggevend argument. Nee, het ligt anders. Met Ivo Stessel als afdelingshoofd (er zijn in de loop van de jaren de nodige functietitels voorbijgekomen) werk ik sinds 1992 samen in dezelfde instelling op dezelfde afdeling, met niet aflatend plezier in het dagelijks werk en in onze onderlinge verhouding. Welke erkenning, waardering krijgt een mens daarvoor? Dit is blijk van mijn erkenning en waardering voor hem. Met Arthur Hegger werk ik nog veel langer samen, nog

voordat ik formeel psychiater werd al. We werkten bij de GLIAGG, één van de rechtsvoorgangers van het huidige Eleos, we zaten jarenlang in de redactie van Psyche & Geloof, we delen daardoor nu met Schreurs en Glas het erelidmaatschap van de CVPPP. Dat schept een meer dan hartelijke band, waar de rol van paranimf helemaal in past.

Trouwens, nu de naam van Agneta Schreurs genoemd wordt, dank ik haar niet alleen voor het co-auteurschap van hoofdstuk 8, maar ook voor haar jarenlange belangstelling voor het project, dat nu dan toch tot een (voorlopige) afronding komt. Ook Hendrika Vande Kemp noem ik hier graag. Zij heeft me met haar belangstelling en kennis enorm geholpen om de Engelse tekst te verbeteren.

Ik ben er tamelijk zeker van dat men beter kan promoveren op jongere leeftijd, zoals onze dochters en schoonzoon, mijn broer en schoonzus, en mijn al te jong overleden zus. Mijn moeder heeft het allemaal meegemaakt, en ook nu is ze er gelukkig nog bij.

In mijn geval werd het een meer of minder sluimerend onderdeel van ons gezamenlijk leven. Mijn vrouw Ineke heeft er alles aan bijgedragen om dit project te doen slagen door mij waar en wanneer ook de ruimte te geven. Daarvoor ben ik haar zeer dankbaar. Dat de omslag van dit boek gesierd wordt door een van haar kunstwerken maakt het nog weer anders tot een geheel. Gewoon gelukkig, ik kan het me niet anders voorstellen dan met jou.

Dit boek gaat over psychiatrie én religie. Dat betekent dat het niet of nauwelijks over religie of psychiatrie afzonderlijk gaat. En toch is, tot slot, de vraag hoe ik me verhoud of ben gaan verhouden tot die bonte schakering aan religies gegeven mijn eigen geloofsovertuiging? Ik moet het ietsje anders formuleren. Ik verhoud me in mijn vak tot al die collega's, waar ook, die hun religieuze en spirituele overtuigingen bedoeld of onbedoeld inbrengen net als ik. Ik geloof niet dat alle religies over hetzelfde gaan, of dat er één centraal thema is dat altijd weer terugkeert, of de kern is van alles, zoals Karen Armstrong dat met buitengewone deskundigheid heeft voorgesteld. Of zoals de experiëntiele-expressieve opvatting over religie ons wil doen geloven. Hoe zou een mens dat trouwens kunnen weten? Het vergt een mensenleven om zich een religieuze of spirituele traditie geheel eigen te maken. Toen ik mijn Hindoe collegae suggereerde om in geval van een religieuze anamnese hun patiënten te vragen welke goden favoriet zijn of juist niet, werd er smakelijk gelachen. Zoiets vraag je niet. Een ernstige vorm van

onkunde mijnerzijds. Hindoes definiëren zichzelf niet met het formuleren geloofsovertuigingen maar met het verrichten van geloofspraktijken. Mensen praten niet over hun goden, maar leven met hun goden in dagelijkse devotie en rituelen. Er is een zekere incommensurabiliteit (hoofdstuk 3). Blijft over: diep respect! Over dat respect valt nog wel iets te zeggen. Dat vergt een eigen spiritualiteit, zoals die bijvoorbeeld is voorgesteld door Smidt-Leukel (paragraaf 6.1).

In dat verband onthoud ik mij dan ook van elk oordeel in de (mijn) overtuiging dat een oordeel bij de Allerhoogste in veiliger handen is dan bij ons. Dat een wijze van zeggen als in deze laatste zin niet zou passen in een wetenschappelijk vertoog, zou in directe tegenspraak zijn met wat ik in dit proefschrift beweer!

About the author

Peter J. Verhagen was born in 1957 in Gouda, the Netherlands. He graduated from the Christelijk Lyceum (pre-university education) in 1975. In that year he began studying theology at the University of Utrecht. In 1976 he also began studying medicine. In 1983 he completed both studies and became medical doctor. In 1988 he became a proponent (a qualified theologian who is permitted to preach) for the Protestant Church in the Netherlands (PKN). He trained in neurology (1983-1985; as a resident under the supervision of Prof. dr. J. Van Gijn), and in psychiatry (1985-1987; as a resident under Prof. dr. M. Kuilman) and in psychotherapy (1987-1988; as a resident under the supervision of Prof. dr. P.J. Jongerius). He registered as a psychiatrist in 1988. He trained in group psychotherapy and is currently supervisor at the Dutch Association of Group Dynamics and Group Psychotherapy (NVGP) and the Dutch Association of Psychotherapy (NVP).

He is member of the Netherlands Psychiatric Association (NVvP) and of the Dutch Association of Group Dynamics and Group Psychotherapy (NVGP), an honorary member of the Christian Association of Psychiatrists, Psychologists and Psychotherapists (CVPPP), and an international fellow of the American Psychiatric Association (APA).

From 1988 to 1992 he worked part-time at the at the psychotherapy department (OEP) of the RIAGG (regional institution for outpatient mental health care) for the Western North Brabant region in Bergen op Zoom. From 1988 to 2000 He worked part-time at the GLIAGG “de Poort” (Protestant institution for outpatient mental health care) in Schiedam, Dordrecht and Amersfoort.

From 1992 he worked part-time at Meerkanten (formerly PZ Veldwijk and currently GGZ Centraal), at the outpatient clinic in Harderwijk, and full time from 2000. Over the years he has functioned as leader of various teams in the short-term treatment program and the continued psychotherapeutic treatment program (personality disorders, autism spectrum disorders and eating disorders). In addition, he has been

actively involved in the training, supervision and work supervision of mental health care trainees (medical doctors, psychologists and psychotherapists).

Professional and other ancillary activities:

- 1991 to 1999: member of the Advisory Committee on Suitability for the Preaching Ministry at the Faculty of Theology, RU Utrecht.
- 1993: member of the editorial staff of the journal *Psyche & Geloof* [Psyche & Faith], of the Christian Association for Psychiatrists, Psychologists and Psychotherapists (CVPPP); from 2009 to 2018 as editor-in-chief.
- 1999 to 2011: member and chairman of the Accreditation Committee for Continuous Medical Education of the NVvP. In 2007-2011 he was chairman of the Implementation Committee for Accreditation Consultations (KNMG), and chairman of the Accreditation Consultation (Dutch national accreditation authority) from 2011 to 2016.
- 2000: member and secretary of the board of the Foundation for Psychiatry and Religion.
- 2000: member of the editorial board of *Groepen. Tijdschrift voor groepsdynamica en groepspsychotherapie* [Groups. Journal for group dynamics and group psychotherapy], journal of the NVGP.
- 2000-2011: member of the board of directors of the Christian College Nassau-Veluwe in Harderwijk.
- 2001-2012: member of the complaints committee of Eleos, Foundation for Reformed Mental Health Care.
- 2002: founding secretary of the World Psychiatric Association Section on Spirituality, Religion and Psychiatry; chair from 2009 to 2014 and honorary member since 2014.
- 2003 to 2007: member of the curatorium of the Theological University in Kampen (ThUK); From 2007 to 2014 member of the advisory board of the Protestant Theological University (PThU).
- 2004: expert member on the behavior concerning abuse in pastoral relationships and authority relationships for the ecclesiastical justice committees within the Protestant Church in the Netherlands (PKN).
- 2007 to 2014: member of the committee for quality review of the NVvP; since 2007 visitor for quality inspection.

- 2011 to 2017: editor-in-chief of *De Psychiater* [the Psychiatrist], a journal of the NVvP.
- 2017: member of the supervisory board of Hezenberg GGZ.

Peter Verhagen is married to Ineke Olbertijn. They have four children: Elise married to Pieterjan, Peter engaged with Floor, Marieke married to Matthijs, and Mark engaged with Chantal.

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