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# Spirituality and Secularity:

# Professional Boundaries in Psychiatry

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## *Abstract*

Spirituality is assuming increasing importance in clinical practice and in research in psychiatry. This increasing salience of spirituality raises important questions about the boundaries of good professional practice. Answers to these questions require not only careful attention to defining and understanding the nature of spirituality, but also closer attention to the nature of concepts of secularity and self than psychiatry has usually given. Far from being "neutral ground", secularity is inherently biased against concepts of transcendence. Our secular age is preoccupied with a form of immanence that emphasises interiority, autonomy and reason, but this preoccupation has paradoxically been associated with an explosion of interest in the transcendent in new, often non-religious and non-traditional forms. This context, as well as the increasing evidence base for spiritual and religious coping as important ways of dealing with mental stress and mental disorder, requires that psychiatry give more careful attention to the ways in which people find meaning in spirituality and religion. This in turn requires that more clinical attention be routinely given to spiritual history taking and the incorporation of spiritual considerations in treatment planning.

## Introduction

Spirituality and religion are now topics of major interest within the healthcare arena, and mental health is no exception. The 2001 Handbook of Religion and Health (H. G. Koenig, McCullough, & Larson, 2001) reviewed 1200 studies on the interaction between religion and health, and research has continued to expand since then (C. C. H. Cook, 2004). The aim of *Mental Health, Religion and Culture*, expressed within the front cover of each issue, is to provide "a forum and a single point of reference for the growing number of professionals and academics working in the expanding field of mental health and religion". The American Psychological Association has a series of publications which provide guidance on the integration of spirituality and religion into psychological assessments and treatments (Aten & Leach, 2009; Miller, 2000; Richards & Bergin, 2000) and a recent major work on religion and psychiatry has been published by the World Psychiatric Association (Verhagen, Praag, López-Ibor, Cox, & Moussaoui, 2010). In the UK, as elsewhere, mental health service users and other patients have expressed concern that they would like to be able to discuss spiritual matters with their doctor/psychiatrist (McCord, et al., 2004; Mental Health Foundation, 2002). As discussed by one of us in a paper in this issue of *Mental Health, Religion and Culture*, spirituality and religion are currently topics of some controversy and interest amongst psychiatrists in the UK, and the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists (SPSIG) provides one arena within which this debate is flourishing.

## Spirituality in Psychiatry: The Current Debate

The recent UK controversy seems to have been sparked off by an editorial by Harold Koenig in *Psychiatric Bulletin* in 2008 (Harold G. Koenig, 2008). Koenig proposed that good psychiatric practice should include the taking of a spiritual history, the support of healthy religious beliefs and the challenging of unhealthy ones, in "highly selected cases" praying with patients, and close working with trained clergy. This editorial generated a vigorous correspondence, including a letter from Rob Poole and his colleagues (Poole, et al., 2008), and a subsequent special article by way of response from the SPSIG (Dein, Cook, Powell, & Eagger, 2010). In brief, the expressed concerns have been that Koenig's proposals in various ways breach proper professional boundaries, that they lack respect for those who reject transcendence, that they open the door to proselytising, and that they risk causing harm (for example to patients with religious delusions). The matter of praying with patients, even though this was something that Koenig himself expressed great caution about, seemed to provide a particular focus for concern.

Papers in this special section of *Mental Health Religion and Culture* make important contributions to the ongoing debate. Rob Poole and Robert Higgo are concerned at what they perceive as "serious breaches of normal professional boundaries" and wish to resist a move towards routine spiritual assessment. They are unhappy with the possibility of patients and professionals praying together, they perceive spirituality as a culture bound concept, lacking in neutrality, and they feel that the SPSIG has exceeded its remit when it adopts what they understand to be a "campaigning role". Secularity, on the other hand, they see as being neutral ground within which science and faith are alike protected. David Crossley, in contrast, draws attention to the way in which the boundaries of the self and the nature of secularity are not well defined in the contemporary debate on the place of

spirituality within psychiatry. How is it possible that psychiatry as a secular discipline engaged in working with and for those who suffer from mental disorder is not clear either about what constitutes secularity or about what the nature and boundaries of the human "self" are? Given this uncertainty, how can we know what the boundaries of secular psychiatry are in relation to the autonomous and integrated self?

Poole, Higgo and Crossley between them raise some important questions, and it is clear especially from Crossley's paper that we will not be likely to find all of the answers from within our own professional boundaries. In contrast to theology, philosophy and anthropology, psychiatry has given relatively little attention to what constitutes the "self" and, although it is often presumed that psychiatry is a secular endeavour, it is also rare to hear debate within the profession about exactly what secularity is. Even if these concepts were more regularly debated amongst psychiatrists (and it is encouraging to see that they are now becoming a topic for debate) it would be arrogant and out of keeping with the multi-disciplinary tradition of psychiatry to imagine that helpful answers cannot be found outside the boundaries of the profession.

## *Secularity and Self*

What, then, is "secularity" and what is the "self"? Charles Taylor, cited by Crossley, has argued that secularity may mean different things, including a falling away of belief in religion and the understanding of belief as just one option amongst others (Taylor, 2007, pp. 1-3). However, although these meanings may often be implied and assumed in psychiatric practice, the general sense in which Crossley suggests that we understand psychiatry as secular is undoubtedly correct. Psychiatry, as a profession, is understood as separate from matters of belief and can be conducted without reference to theology, doctrine or notions of transcendence. Or can it? The problem is that psychiatry is intimately concerned with what patients believe and it has undoubtedly shown a propensity in the past to label religious beliefs as pathological. That religious beliefs are now more respected within psychiatry, and that they may be seen as helpful and adaptive rather than necessarily pathological, is a tribute to the extent to which the profession has become more willing to engage with and understand the diversity of spiritual and religious beliefs and practices that are encountered amongst healthy and flourishing people in the world today. In other words, whether these beliefs are falling away or not (and it is not at all clear in most parts of the world that they are), they are still very much a part of the human landscape that psychiatrists need to reckon with.

However, Taylor's analysis has more to contribute to our present debate. Taylor argues that our current secular age is characterised by "closed world structures" which make transcendence appear to be much less of a live option than it really is. The power of these structures is that they are not recognised for what they are. It is in this way that they restrict our grasp of reality and, in particular, restrict our grasp of the transcendent. One of the ways in which this happens, Taylor argues, is by the prioritisation of the knowing self, such that anything that is not immanent is suspect (Taylor, 2007, pp. 557-558). It is this that simultaneously privileges scientific knowledge and makes secularity appear to be "neutral" ground when in fact it is not. It is deeply biased against the transcendent.

Taylor's analysis of the self is also revealing (Taylor, 1989). The deep sense of inwardness, and the radically self-reflexive stance, that is adopted in contemporary understandings of the self has its origins in Christianity but is now also strongly informed by Romanticism (leading to a sense of good inner resources which must be tapped) and an emphasis on everyday life as the arena within which self-identify is formed and becomes known. This has important implications for psychotherapy, and it is therefore not surprising that many therapists have incorporated notions of spirituality (both as immanent inner resource and as transcendent reality) within their practice.

Taylor's analysis, which is a searching and complex treatise, only the surface of which has been scratched here, has important implications for psychiatry. In particular, attempts to close down the transcendent option, or to argue that psychiatry has nothing to do with spirituality, are more likely to be the result of the operation of hidden closed world structures which distort the appearance of reality than they are to be protective mechanisms which preserve healthy professional or ethical boundaries or defend personal religious belief.

## *Spirituality*

Taylor's work also deals with what he refers to as the "nova effect", which presents us (at least in the western world) with an "ever widening variety of moral/spiritual options"(Taylor, 2007, p. 299). It is in this context, not the context of traditional religion, that spirituality has become an important topic. It is important not just for psychiatric practice, but for a proper philosophical account of the self-understanding of all human beings in our secular age. This is not to say that all human beings will self-identify as "spiritual", but that the spiritual and moral options presented to us (including the option to self identify as "not spiritual") are more numerous and diverse than ever before. Just as the option to self identify as "non-political" is a political statement, and does not refute the existence of politics as an important concern of the human social order, so the option to be "non-spiritual" is a spiritual self-statement which does not in any way undermine the value of spirituality as an important concept, descriptive of an important aspect of human self-understanding.

*Pace* Poole and Higgo, spirituality is not a "doctrine" or a theology. It does not require belief in God and it does not presume any particular set of teachings or beliefs. Neither does it imply any kind of ecumenism or syncretism or perennial philosophy. It is a way of talking about such things as transcendence and immanence, relationship, meaning and purpose which are peculiarly human (C. C. H. Cook, 2004). Undoubtedly there are those who feel that it is a concept without merit, or that it has no integrity or validity. However, to deny the use of the word/concept would still leave issues such as transcendence and immanence as important topics of discourse for human self-understanding and other words and concepts would still be needed in order to have the same kind of conversation. Spirituality has emerged as a way of talking about such things because it does not require either doctrine or theology. For many people it will be inseparable from religion, but for others it is antithetical to religion. Discussion about spirituality does not require that one adhere to, or deny, any particular religious tradition, or belief system or worldview. In this sense, it is a completely neutral concept which provides common ground for discourse about important aspects of human self-understanding which would otherwise not easily be possible in our secular age.

## *Boundaries*

What then should be the boundaries of conversation about spirituality within psychiatry? Boundaries may be professional, therapeutic or ethical. These will overlap and may conflict to varying degrees, posing dilemmas for the psychiatrist. What if the psychiatrist feels it is outside his/her professional competence as a psychiatrist to discuss particular spiritual issues with the patient, but that it is nevertheless therapeutically important that for a particular patient such issues should be addressed? What if it is felt to be spiritually beneficial for a patient to explore a particular spiritual tradition to which the psychiatrist subscribes, yet no advice or support for doing so must be offered in case it would be taken as proselytising and therefore would breach an important professional ethical boundary? These kinds of boundary issues are not unusual in psychiatry, and would be more easily managed if a set of guidelines existed for psychiatrists in the UK similar to that adopted by the American Psychiatric Association (Committee on Religion and Psychiatry, 1990).

The guidance that the GMC provide to all doctors registered for practice in the UK includes, as Poole and Higgo point out, safeguards that prohibit doctors from sharing their beliefs with patients in such a way as to exploit vulnerability, or cause distress, and also an injunction against putting pressure on patients to "discuss or justify their beliefs". These are specific applications of general principles of good professional practice. It is never acceptable to exploit the vulnerability of patients. Nor is it acceptable to cause them avoidable distress, or to put pressure on them to discuss or justify anything that they do not wish to. However, all doctors have been faced with the situation at some time or another where their duty of care requires that they impart distressing information, or that they broach subjects which patients would rather not discuss. In the practice of psychiatry such tensions can arise in many aspect of personal history taking or mental state examination, including discussion about intimate relationships, enquiry into forensic history, exploration of delusional beliefs, or feelings of guilt. In a similar way, spiritual and religious concerns may easily be avoided when it may be therapeutically important that they be discussed. This is implicitly acknowledged, although not explored in detail, in GMC guidance to doctors which states 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 patients to address their particular 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. (General Medical Council, 2008)

## *SPSIG*

The SPSIG has not been prescriptive in its approach and has not thus far adopted any position with regard to guidelines on good practice, although the possibility that such guidance might be explored in future is not excluded. If it has "campaigned" at all, then it has campaigned for better education of psychiatrists about spirituality, for wider awareness of the need to consider spirituality and religion in psychiatric assessment and treatment, and for more openness to talking about these topics both

within and with those outside the profession. It has not promoted discussion of such matters with patients who "resist" such discussion, it has not promoted praying with patients, and it is opposed to proselytising amongst patients in any form.

The SPSIG does exist to promote discussion amongst professionals, such as the discussion that is taking place within the pages of this issue of *Mental Health, Religion and Culture*. Members of the SPSIG have diverse views on the matters that are being debated here, and very possibly some will agree with the views expressed by Poole and Higgo, whilst others will equally strongly disagree. In the preface to *Spirituality and Psychiatry*, a book which was conceived by the SPSIG and published by RCPsych Press, it was stated by the editors that they expected the book to be provocative, but that there was no expectation that everyone could or should agree with the views expressed by authors within it (C. Cook, Powell, & Sims, 2009, p. xiv). As with all special interest groups within the Royal College of Psychiatrists, views expressed do not represent a position taken by the College unless formally approved and published as such.

A good account of what the SPSIG has campaigned for (if it is to be called "campaigning") is in fact well stated by Poole and Higgo:

> Psychiatry is a profession that depends on a detailed and sophisticated understanding of patients' lives. Little can be understood about mental distress without a good grasp of social and psychological context (Poole & Higgo, 2006). Psychopathology is assessed predominately by use of methods borrowed from phenomenology, a technique that rests on empathy and an understanding of the individual's internal experience. Religion and spirituality are important ways in which many people organise their understanding of the world. They form a configuration of ideology, ritual and social practice that profoundly affect the way that lives are led and experienced. All psychiatrists have to be able to understand religion and spirituality, together with many other aspects of lives and cultures that may be very different from their own. These are empathic skills that are essential to the reliable application of our science. They are not optional, nor do they depend on our own personal attitudes to matters of faith.

## *Why the Controversy?*

Given this clear measure of agreement on what is important, it is still unclear why Koenig's 2008 editorial in *Psychiatric Bulletin* generated quite so much controversy. It is also unclear why Poole and Higgo interpret the SPSIG campaign (sic) as proposing "serious breaches of normal professional boundaries of behaviour". In another paper in this issue, one of us has suggested four possible reasons why spirituality and religion might have the potential to cause a heated response:

a) There is a transatlantic cultural difference which makes the proposals of Koenig and others appear more controversial in the UK than they may be in the US

b) There are misunderstandings about the differences between spirituality and religion

c) The discussion of spiritual or religious matters with patients might be found by clinicians to be personally challenging or threatening in some way, perhaps because it is seen as transgressing professional boundaries

d) The discussion of spiritual or religious matters with patients might be perceived as potentially harmful

Poole and Higgo, in their article in this issue of *Mental Health, Religion and Culture*, do not appear to acknowledge the first or second of these possible reasons, but they do clearly agree with the third and the fourth, those relating to boundaries and harm. We do not feel that a reasoned discussion about the nature of the professional boundaries involved should be a cause for concern, and some of the important differences between different kinds of boundaries have already been discussed, above. It is possible of course that other boundaries are important here – such as the boundaries of what Taylor refers to at the "buffered self", a self which is potentially threatened by discussion of spiritual and religious matters. This is another feature of secularity which would appear to render the secular domain much less than neutral for discourse on the topic at hand.

The matter of the harm that may be caused by bringing spirituality or religion into the clinical consultation is an important one and undoubtedly deserves much more research and study than it has hitherto received. Poole and Higgo provide examples known to them of the ways in which prayer can undermine a therapeutic relationship or worsen a patient's clinical condition, the complications that can arise from an explicitly acknowledged shared faith perspective between doctor and patient, and the impairment of clinical judgment that can emerge when the justification for clinical interventions is argued on religious rather than scientific grounds. We recognise and agree with these concerns, and could add more examples of our own. Further evidence for concern, if such is needed, is provided by Galanter's important study of the impact of evangelical belief on clinical practice in the US (Galanter, Larson, & Rubenstone, 1991). However, it is hardly surprising that examples of poor practice may be found when there have been so few opportunities afforded by medical training and continuing professional development within which to discuss good practice in this domain. It is at least partly to remedy this deficiency that the SPSIG was founded. We do not feel that a ban on all discussion of spirituality and religion within the consulting room would actually help at all. Rather, it would be likely to render the abuses of such privilege more deeply hidden whilst simultaneously impeding the possible therapeutic benefits of good practice.

## *Summary*

In conclusion, it is suggested that secularity provides far from neutral ground when it comes to managing the good and bad influences of spirituality and religion on the clinical practice of psychiatry. This does not mean that psychiatry must be practised in a religious context, but it does mean that exploration of spiritual matters in the clinical context needs to be informed by better understandings of the hidden assumptions of the secular age in which we live and of the complex nature of the buffered self that this age has fostered. Such understanding is aided by the kinds of exchange that are to be found within the pages of this issue of *Mental Health, Religion and Culture* but it also requires to be addressed within professional training and in continuing professional

development. Groups such as SPSIG, whether perceived as "campaigning" or not, have an important part to play in assisting this process.

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