COMMENTARY

Religion and psychiatry: research, prayer and clinical practice†

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SUMMARY

Religious concerns, manifested in thought and behaviour, have a complex, bidirectional and sometimes conceptually overlapping relationship with mental health and mental disorder. Psychiatry, concerning itself with what is measurable in research, and with the relief of distress in clinical practice, has a different perspective on these complex interrelationships than does theology or religion. That which is transcendent, and therefore not measurable, is often important to patients, and sometimes distress may (theologically) be a sign of human well-being. The giving of careful attention to transcendence and distress may variously be conceived of as prayer, religious coping or clinical care. Applications of research to clinical practice, addressing as they do a sensitive and controversial boundary between psychiatry and religion, must therefore be patient centred and culturally sensitive.

Keywords

Religion; psychiatry; mental health; transcendence; prayer; patient-centred practice.

Religion and psychiatry have not been known for their cordial relations. Like science and religion more widely, they are often perceived to be at odds with each other whereas, in fact, they shed different light on shared concerns. This is not merely an academic debate; it has an impact on whether and how patients are able to place their trust in the mental health professionals whose vocation it is to help them find healing and recovery.

Religion and spirituality in psychiatric research

In the first of two articles on religion and psychiatry that they present in *BJPsych Advances*, Koenig et al (2020a) focus attention on religion and religiosity as appropriate concepts for psychiatric research. Spirituality, they point out, is difficult to define and hopelessly confounded with the dependent variables that it is purported to influence. This cuts to the heart of the problem. Exactly how do we scientifically measure a variable concerned with something that is ultimately transcendent? The solution in practice has been to measure such things as private or public religious activities, to ask people about the subjective experience of their religion and its importance in their lives, or to attempt to assess whether and how religion is used in coping with illness and adversity. Often, it is the thing that is easiest to measure that is measured, and this is frequency of religious attendance. However, this is not necessarily what most religious people (not to mention those who identify as spiritual but not religious) consider to be the most important thing. For example, in a large 2014 survey of Christians in the USA (Pew Research Center 2016), 86% considered belief in God to be an essential part of what it means to be a Christian, but only 35% considered attending religious services to be essential. Among other things, gratitude (71%), forgiveness (69%) and praying regularly (63%) were all rated as more important than attending services.

Intrinsic and extrinsic religiosity

In their seminal paper distinguishing between intrinsic and extrinsic religiosity, Allport & Ross (1967) referred to intrinsic religiosity as providing the 'master motive' in life. This contrasts with extrinsic religiosity, in which a concern with social appearances dominates. Large numbers of publications since have confirmed that intrinsic but not extrinsic religiosity is associated with better health outcomes. However, master motives are still motives, psychologically formed within the human mind. Spirituality and religion are concerned with the impact of the transcendent on human minds and brains, but the transcendent is not scientifically observable; we cannot measure God. Whereas theology and religious studies may attend to such things as the nature of the divine, the meaning of divine revelation and so on, in scientific research spirituality and religion will only be observable as psychological variables.

Although public and private devotional practices are (at least in principle) objectively measurable, the things that are most theologically interesting are much more subjective. Intrinsic religiosity is measured, for example in the Duke Religion Index (Koenig 2010), on the basis of such statements as 'In my life, I experience the presence of the Divine (i.e., God)' and 'My religious beliefs are what

really lie behind my whole approach to life'. Intrinsic religiosity, like spirituality, is intimately connected with psychological states and traits. When depressed, God may seem absent and life no longer worthwhile, when happy God may feel very near. Conversely, for the religious person, an experience of the absence of God is likely to be associated with low mood. The experience of the presence of God is both a religious and a psychological variable. As Koenig et al point out, the relationships between religious concerns and mental health are bidirectional and complex, but they are also intimately interwoven and – at least sometimes – perhaps conceptually inseparable.

'Positive' and 'negative': a matter of viewpoint

Theologians often have a different view of what is positive and what is negative in human lives than do psychiatrists and psychologists. The prejudicially labelled concept of 'negative religious coping', usually measured using the RCOPE (Pargament 2000), encompasses such things as spiritual and religious struggles, which can undoubtedly be psychologically distressing experiences, but are usually perceived theologically as the context within which spiritual growth may take place. Spiritual growth, when measured in psychological research (e.g. Wilt 2019), is usually defined in positive terms, but sometimes negative psychological experiences may be construed in theologically positive ways. The concept of moral injury provides an interesting example of this. Defined by Koenig et al (2020a) as 'negative emotions that emerge following transgression of moral boundaries during combat operations […]; failing to protect [others] from harm; or observing others behave in this manner', its symptoms include guilt, shame, self-condemnation, loss of trust and religious struggles. Identified as a 'syndrome' (which may occur outside the military context as well as in combat) it is associated with post-traumatic stress disorder, depression, anxiety and risk of suicide. Yet, we may wonder who is mentally well and who unwell? In the midst of intolerable and extreme circumstances, when forced to make life and death decisions in fractions of a second, how does a good human being behave, and how do they feel afterwards? Is the good man or woman the one who comes through untouched, or the one who struggles with the enormity of what they have seen and done? Perhaps sometimes resilience is reflected more in the courage to engage in such struggles than in escaping them (Cook and White 2020)?

Religion and spirituality in clinical practice

Religion is concerned with an orientation towards the transcendent amidst the painful and distressing realities of the immanent order. Psychiatry is concerned solely with the immanent reality of the mental pain and distress, but it should not forget that those whom it seeks to heal often (on a worldwide basis, usually) believe in the transcendent. In their second article, Koenig et al (2020b) draw attention to some of the challenges that arise when attending to spirituality and religion in clinical practice. Particular cultural and religious contexts shape our understanding both of the challenges themselves and of our estimation of what we consider to be good responses to them. What might appear a good idea in the USA may not seem so good in the UK, and controversies about praying with patients seem to be one example of this. However, transatlantic reflections might help each of us to see our own practice differently and to envision something better. What does it mean, for example, to 'pray' with a patient? This has previously been debated in the *British Journal of Psychiatry* (Poole and Cook 2011), and I will not repeat the arguments here. However, any ethical answer to the question will necessarily be patient centred and culturally sensitive. Attentive listening to a patient's spiritual struggles may well be a form of prayer as understood by many religious clinicians, but it is also good clinical practice.

Is mindfulness a religious/spiritual intervention?

Koenig et al do not include mindfulness among the religious/spiritual interventions that they consider. Mindfulness interventions are probably much more widely available in the UK than the religiously/spiritually integrated psychotherapies that they do consider. Understood as a form of attentive awareness of the present moment, mindfulness is recommended by the National Institute for Health and Care Excellence (2009) as effective in relapse prevention for depression. Although it has origins as a Buddhist spiritual practice, it has much in common with Christian contemplative prayer. This raises some interesting questions. If doctor and patient may not pray together, may they be mindful together? Why might some spiritual practices be acceptable in the clinical context and others not?

Spirituality/religion and psychiatry operate in a dynamic and complex relationship with each other; this needs to be managed with sensitivity and care by psychiatrists and mental health professionals, as well as by chaplains, clergy and other religious leaders.

Declaration of interest

C.C.H.C. is a past chair of the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists.

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