

CONCEPTUAL BASES OF PSYCHIATRY FOR THE PERSON

Spirituality, Religion and Psychopathology: towards an integrative psychiatry

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Introduction

The concepts of person-centred medicine and of 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 centred psychiatry offers a well grounded reason for incorporating spirituality and religion into psychiatric assessment, diagnosis, case-formulation, therapy, and as a component of psychiatric training and continuous professional development.

In this paper we consider the need for increased understanding of the nature of religious belief and of the variety of spiritual practice if a truly person centered psychiatry is to be practiced.

Psychiatry sits on a three-legged stool of science, art and ethics [1]. Its provenance therefore includes understanding the spirit (soul) of patients, their Weltanschauung (View of the World) and the quality and meaning of their personal and professional relationships. The bio-psychosocial model of George Engel was based on general systems theory and yet successfully encouraged doctors to consider the social and psychological aspects of patient care in addition to biological parameters. The model however was considered primarily as a causal scientific framework, which could neglect its full potential to promote a humanistic person centered medicine. A biosocial/psychospiritual relationship based approach to health care provision is perhaps therefore closer to the

essence of a Psychiatry of the person [2] as it is within this wider perspective that consideration of religious faith and spiritual practice optimally resides.

Paul Tournier, pioneer of 'medicine of the person', encouraged crossing the boundaries of science, spirituality and psychology within the specific context of the doctor-patient relationship [3]. This bridging of disciplines is facilitated by new knowledge of the complexity of neuronal circuits, and recognition that religious belief has a partial origin in brain function and yet also determined by metaphysical events and transformational experiences. For Tournier, a Genevan family practitioner, there were no contradictions between his understanding of religious belief, the importance of spiritual practice (meditation), the dynamic of personal growth, and the scientific/biological exploration of illness for the optimal practice of medicine.

Definitions

Domains of spirituality (the quality of being spiritual) and of religious practice overlap; most religious traditions encourage adherents to undertake private spiritual exercises such as prayer and penance, as well as attending the Mosque, Temple, Synagogue or Church.

A distinction between Intrinsic (personal, subjective) religiosity and Extrinsic (rules and regulations, creeds and disciplines) religiosity is nevertheless useful. Intrinsic religiosity is a more personal spirituality derived from, and structured by, Religious tradition. Whereas Spirituality is a private quest for answers to ultimate existential questions about life and death, meaning and purpose, and can include

experiences of the transcendent. Continental philosophers (including Merleau-Ponty) were influenced in their understanding of subjectivity by the ‘face’ of the other (Levinas) and the I-Thou relationship [4], as well as by the Judeo Christian faith tradition. Their conceptual contribution to person centred psychiatry and to the wider domain of medicine has yet to be fully appreciated [5].

movement. Personalised medicine, however, is not necessarily a medicine of *the person* which is contingent on the quality of the therapeutic relationship and specifically on an integrative approach to the mind, the body and the spirit.

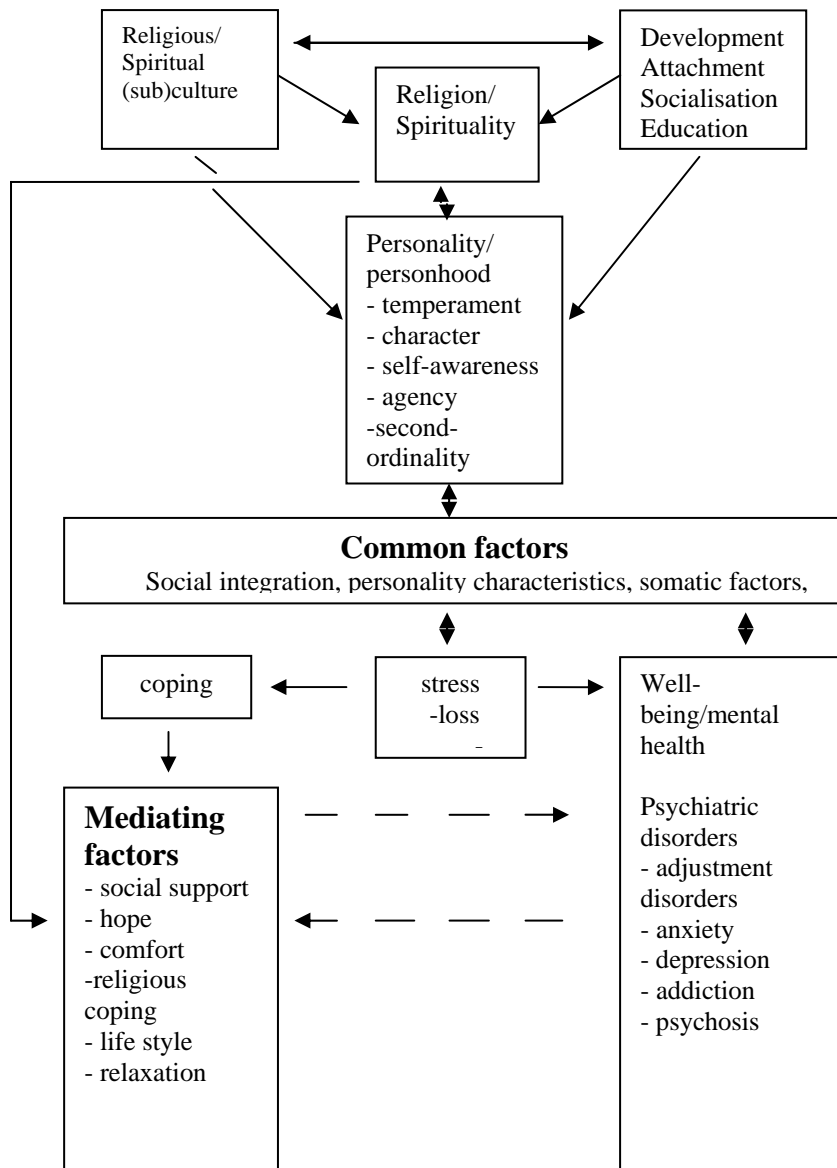
Person-Centred Medicine

Many current policy initiatives from WHO as well as from national health departments advocate a more person-centred healthcare and have their origins in consumerism as well as altruism; and are driven by the User and Carer

Religion and psychiatry

Sims [6] has written succinctly about the need for religious knowledge when eliciting patients’ psychopathology, establishing a differential diagnosis, and making comprehensive management plans. The religious coloring of mental symptoms such as hearing God’s voice, visions of angels, brass bands playing “Rock of ages cleft for me”,

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



near death experiences and mystical states demand a mastery of clinical assessment skills as well as cultural competence. Jaspers's distinction between understanding (connectivity) and explanation, as well as between static and genetic facets illustrates well the contribution of philosophical thinking to daily clinical practice and to the relevance of understanding beliefs.

Putting things together

This field is complex as 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, and yet can cause emotional distress and trigger mental disorder.

Research summarized by Koenig et al. [7], 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*', make links, between religion and health.

Factors in common include genetic, biological, developmental, personality and social factors. Whilst mediating factors include social support, hope, confession and prohibitions on diet and alcohol. (Fig 1)

Working together: implication for training

This multidimensional approach to the understanding of spirituality and psychopathology requires a multidisciplinary paradigm. Psychiatrists should therefore be exposed to training in 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 can be a component of an ethics or transcultural psychiatry course, which should facilitate awareness of the doctor'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 trained in theology, have a particular 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, e.g. King et al [8] and several major literature reviews.

There is a pressing need for more evaluative studies of the bio-social /psycho-spiritual 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 each necessary to show whether or not this way of working is cost effective as well as humane and ethical.

Conclusion

There is a growing awareness in clinical medicine of the need to consider the wholeness of individual persons (health professionals and patients); and to cross more frequently the boundary of 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 need now to be given a renewed priority [9].

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