Mental Health, Religion & Culture

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/cmhr20

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To cite this article: Christopher C.H. Cook (2020) Spirituality, religion & mental health: exploring the boundaries, Mental Health, Religion & Culture, 23:5, 363-374, DOI: 10.1080/13674676.2020.1774525

To link to this article: https://doi.org/10.1080/13674676.2020.1774525

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Published online: 13 Aug 2020.

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MENTAL HEALTH, RELIGION & CULTURE
2020, VOL. 23, NO. 5, 363–374
https://doi.org/10.1080/13674676.2020.1774525

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Spirituality, religion & mental health: exploring the boundaries*

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ABSTRACT
The Spirituality and Psychiatry Special Interest Group (SPSIG) of the Royal College of Psychiatrists was established in 1999 in the historical context of increasing research and clinical interest in a more positive understanding of how psychiatry and spirituality/religion (S/R) might work together in addressing common concerns. Since then, SPSIG has made a significant contribution to clarifying the professional boundaries of S/R in psychiatry in debate and in clinical practice. The conceptual boundaries of S/R in relation to psychiatry are complicated by the psychological nature of the terms in which spirituality is usually defined. Religiosity and mental health are also found to have a bidirectional influence upon each other. Acknowledging the conceptual overlap, it is proposed that spiritual and mental wellbeing are both marked by a willingness or ability to be attentive to things that matter.

ARTICLE HISTORY
Received 4 March 2020
Accepted 22 May 2020

KEYWORDS
Spirituality; religion; mental health; psychiatry; boundaries; policy

As the Spirituality and Psychiatry Special Interest Group (SPSIG) celebrated its 20th birthday in 2019, it is a good time to look back at where we have come from and to reflect on some of the challenges that presently lay before us. What I offer here is a personal view, and my attention to the literature and events of the last 20 years or more has necessarily been selective.[1] However, it seems to me that we have made a significant journey, and I would like to reflect on some of the landmarks and milestones along the way as I have seen them. This journey has taken us through some badly mapped territory. Looking back, and with the benefit of some new maps, I wonder whether we might find some greater clarity about its boundaries.

Historical context

Freud loomed large over the history of religion and psychiatry in the twentieth Century, casting a dark and lingering shadow. Unlike Dawkins, he did not assert that religion was

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*This paper was originally presented as a plenary address at the 20th Anniversary day conference of the Spirituality & Psychiatry Special Interest Group, at the Royal College of Psychiatrists, on 29th November 2019. Minor changes have been made to the transcript to adapt the paper to the written format.

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a delusion (he knew his psychopathology better than that) but he did think that it was an illusion. It was – in his view – motivated by wish fulfilment. It was not open to verification or disconfirmation; nonetheless, he knew it was false. So widely known was this view that for decades it set psychiatry and religion in opposition to one another in the popular imagination. The boundary between the two became something of a beachhead, with the forces of psychiatry seen as making relentless advances into the land of religion.

Ironically, as scientific research in psychology and psychiatry advanced, psychoanalysis fell foul of similar criticisms. It too was not open to scientific verification or disconfirmation. It was evidence-based medicine, not psychoanalysis, that was increasingly to shape the relationship between religion and psychiatry. Combined with professional debates about good clinical practice, this turning tide brought into view a very different strandline between the worlds of religion and psychiatry.

In 1989, the Assembly of the American Psychiatric Association approved guidelines regarding the conflict between psychiatrists' religious commitments and their clinical practice. The guidance, published in the American Journal of Psychiatry in 1990 (Committee on Religion and Psychiatry, 1990), cited only four brief examples of cases illustrating potential concerns, but it soon became clear that the problem was bigger than this. In a paper by Marc Galanter and his colleagues, in the same journal in 1991, evidence was presented to show that the practice of some evangelical Christian psychiatrists was influenced in significant ways by their faith. As a group, they thought that the Bible and prayer were more effective treatments for some conditions than medication or psychotherapy. Around half of them allowed their Christian views on sexuality to influence their advice to their Christian patients. A third of them allowed these views even to influence their advice to other patients. The boundary that now came into sight was not so much the one between religion and psychiatry, but the one between good professional practice and bad practice. It is to the credit of the APA that they recognised this at least ten to twenty years ahead of the rest of the world and that they introduced a clear statement of policy to address it.

Back in the UK, in the Royal College of Psychiatrists, things were also beginning to change. In 1991 HRH The Prince of Wales addressed the College as its patron, drawing attention to the spiritual task that he understood to be at the heart of mental healthcare (HRH The Prince of Wales, 1991). In 1993 successive presidents of the College drew attention to the importance of spirituality at College meetings. Andrew Sims, in his valedictory address as President, warned that psychiatrists neglect the spiritual realm at their patients' peril (Sims, 1994). John Cox, as incoming president, pointed out that in a plural society religious perspectives were an important part of being a culturally aware psychiatrist (Cox, 1994). And then, in 1996, in an unprecedented invitation, the Archbishop of Canterbury, George Carey, addressed an annual College meeting. In trying to address the question of how barriers between religion and psychiatry might be transcended, he reflected that religion and psychiatry share much in common. Both are concerned with more than the merely physical. Society needs religion and psychiatry to work together for the common good of people who struggle with mental illness (Carey, 1997). All four of these figures, in different ways, told the College that we need to be crossing traditional boundaries and breaking down barriers. All four saw this as imperative for the wellbeing of our patients. It was in this context that our SIG was born.

The Spirituality & Psychiatry Special Interest Group

In 1999, at the initiative of Andrew Powell, a proposal for a Spirituality and Psychiatry Special Interest Group was published in the College *Bulletin* (Shooter, 1999, p. 310). The proposal stated that the new SIG would:

> facilitate the exchange of ideas on a wide range of topics, including the significance of the major religions which influence the values and beliefs of the society in which we live, also taking into account the spiritual aspirations of individuals who do not identify with any one particular faith and those who hold that spirituality is independent of religion.

The intention was expressed to study "experiences invested with spiritual meaning", mystical and trance states, transformative and pathological states of mind, and "protective factors which sustain individuals in crisis". (p. 310)

Having gained the necessary support of 120 College members, the inaugural meeting was held, in the Council Room of the College, in its old premises at 17 Belgrave Square, on 24th September 1999. As I recall, the room was packed and I spent most of the meeting perched on a window sill. Andrew was duly elected as the first Chair.

From around the time that we had our first meeting in Belgrave Square, or perhaps just a few years before this, research publications on religion and psychiatry began to increase exponentially. We owe much to Harold Koenig, at the Duke University Centre for Spirituality, Theology & Health, in North Carolina, for his encyclopaedic cataloguing of this literature in a series of volumes that he has written and edited jointly with distinguished colleagues (Koenig, 1998; Koenig, 2018; Koenig et al., 2001; Koenig et al., 2012). We should also note an important collection of essays published by the World Psychiatric Association in 2010 (Verhagen et al., 2010). However, this is just the tip of the iceberg. Below the surface, as it were, literally thousands of peer-reviewed quantitative studies were being published in scientific and medical journals; not to mention qualitative studies which probably now run into the tens of thousands. This evidence base has been hugely important both in persuading sceptical colleagues that spirituality and religion are important in psychiatry and also in forcing us all to question exactly what the nature of the boundaries between spirituality, religion and psychiatry are.

Going back to Belgrave Square, the SPSIG was increasingly concerned about clinical practice – both because of the professional challenges faced by its members, but also because of its concern for the impact of poor practice upon patients. As we knew from discussions with colleagues at the WPA, these concerns were clearly shared by psychiatrists in other countries. In 2005, I suggested to the SIG Exec that we should submit a proposal to the WPA Section on Religion, Spirituality and Psychiatry for a position statement on spirituality and religion in psychiatry which might clarify some of the key things that we could mutually affirm. The Exec agreed, and I was asked to draft the document. My original proposal fitted nicely on one page of A4, with just five things that I hoped we could together affirm as a profession.

It proved to be much more difficult to get international agreement on this proposal than we had hoped. By mid-2008 it had grown to a page and half, with eight affirmations, but still no agreement.

But then other events took over. Harold Koenig published an editorial, entitled "Religion and mental health: what should psychiatrists do?" in *Psychiatric Bulletin* (Koenig, 2008b).

This piece, which – for the most part – didn't really say anything that hadn't been said before from College platforms, ignited a heated published correspondence amongst College members in the *Bulletin* and in other journals. At the vanguard of those who expressed concerns was Rob Poole. Concerns expressed by Poole and others focussed to a large extent on professional boundaries. Some of Koenig's suggestions, they wrote, "constitute serious breaches of professional boundaries" (Poole et al., 2008, p. 356–357). In particular, spiritual history taking, the supporting and – when necessary – challenging of spiritual/religious beliefs, and praying with patients were highlighted for concern. The debate continued for years in the *Bulletin* and in other journals. Indeed, it still continues to this day.

In this context, and with no agreement in sight on the international front, the SIG Exec decided that it should focus its efforts within the Royal College of Psychiatrists. The draft position statement, written originally for WPA, was redrafted yet again and submitted to the Registrar as a proposal for College policy. After a debate in the Policy Committee, and further work with the Professional Practice and Ethics subcommittee, the College published its Position Statement *Recommendations for Psychiatrists on Spirituality and Religion* in 2011, later to be updated in 2013 (Cook, 2011, 2013). Getting agreement on this was no small miracle, but unsurprisingly the document was not welcomed on all sides. Professor Poole, in a letter in the *British Journal of Psychiatry*, wrote that:

> This debate has teeth, and we are already set on a course that I find extremely worrying. Those who agree with me on the importance of boundaries should make their voices heard now, as we may soon find ourselves in a very difficult place. (Poole, 2011, p. 518)

In 2014, Alexander Moreira-Almeida took over as Chair of the WPA Section on Religion and Psychiatry and put the WPA position statement on his action plan. The draft position statement was resurrected and redrafted and finally agreed by the WPA Executive Committee in September 2015. This version of the document turned out somewhat differently in the end, but its recommendations still have a lot of common text with our Royal College position statement (Moreira-Almeida et al., 2016).

In an editorial in the *British Journal of Psychiatry* earlier this year (2019), Rob Poole and I, together with Robert Higgo, tried to clarify some of our agreements and disagreements about how these policies may or may not be helpful in addressing our ongoing disputes about the boundaries between spirituality, religion and psychiatry (Poole et al., 2019).

Where, then, does this leave us now with regard to the boundaries that have proved so controversial both in research and clinical practice? Boundaries mark limits. They provide a dividing line between one area and another. When we talk about boundaries between abstract concepts such as spirituality, religion, or mental health, we push the metaphor to its limits. Is it even possible to talk about boundaries in relation to such concepts?

Spirituality

From the outset, the SPSIG defined itself primarily in terms of spirituality, rather than religion. Spirituality was seen as being the more inclusive term and it has become increasingly popular. The title of one of the pioneering sociological studies, by Paul Heelas and Linda Woodhead in 2005, sums it all up rather well: *The Spiritual Revolution: Why Religion is Giving Way to Spirituality*. In a society such as ours, where many people self define as spiritual but

not religious, it is tempting to conclude that the revolutionary forces have won. However, things look rather different globally, where the vast majority of people still consider themselves to be religious.

Spirituality is problematic in research. Commonly concerned with things such as meaning and purpose in life, with the human being in a relationship, and especially the relationship with a transcendent order, it is difficult to define, and even more difficult to measure. It is subjective and highly confounded with the psychological variables that it purports to influence. People who are depressed, for example, commonly lose any sense of meaning and purpose in life and they view their relationships differently. They feel rejected by God; but this is the effect of depression, not its cause.

One of the most widely used measures of spirituality in research has been the Spiritual Wellbeing Scale, devised by Paloutzian and Ellison in 1982. It comprises 20 self-report items, each inviting a response on a six-point scale from "strongly disagree" to "strongly agree". Ten items are taken to measure religious wellbeing and ten to measure existential wellbeing. The latter is especially problematic. For example, is the item "I feel that life is a positive experience" really about spiritual wellbeing or is it a measure of a psychological state, or trait? It is certainly meaningless in research to suggest that we have learned anything by discovering that people who respond negatively to such questions are also depressed. The so-called measure of spirituality is simply measuring one aspect of depression.

Because of this, Koenig has argued that – unless we can find some new measure of spirituality that is not confounded with psychological variables – we should stop deceiving ourselves and turn to measuring religiosity in research, rather than spirituality (Koenig, 2008a). That is not to say that the concept of spirituality is not useful in clinical practice. It is. However, it is not terribly useful in research.

The SIG has done its bit to try and chart the boundaries of spirituality in relation to clinical practice. In 2009, on our tenth anniversary, *Spirituality and Psychiatry* was published by RCPsych Press, a book conceived from within the SIG and with contributions primarily from SIG members (Cook et al., 2009). An expanded and revised second edition is currently in preparation, with publication expected in 2021.

In 2016, RCPsych Press published another book – also conceived within the SIG – *Spirituality and Narrative in Psychiatric Practice* (C. Cook et al., 2016). This was more about the stories that we tell, rather than the boundaries that we map, but stories are an important way in which we clarify meanings. At the risk of mixing metaphors, they are one of the tools that we use in order to draw up our mental maps.

I find it interesting that the cover images of these books – selected by staff from the College publications team – evoke, respectively, the inner and the outer journeys in life that spirituality represents.

Religion

Religion is actually just as difficult to define as spirituality, and much of the scientific literature appears to demonstrate blissful ignorance of this. However, religiosity is measurable by such things as church attendance, religious affiliation or frequency of prayer, bible reading or other religious practices. These measures are not confounded with mental wellbeing in quite the same way as most spirituality scales are, but the relationships are still

complex. The depressed person typically stops going to church, and feels abandoned by God. She may – at least initially – pray more, because prayer is a widely used means of religious coping. However, she may also abandon prayer. In other words, religiosity may be both cause and effect in relation to mental wellbeing.

Regardless of these problems, good clinical practice recognises that religion is an important part of understanding people in context. Person-centred care explores the impact that illness has upon faith, and the impact that faith has – for good or ill – upon the illness. Recognition of the importance of this is, I believe, finally winning the day in the lingering warfare between psychiatry and religion.

The Duke University Religion Index (DUREL) (Koenig & Büssing, 2010), is a short, five-item, instrument used for measuring religiosity in epidemiological studies. The instrument has three subscales: organisational religious activity, non-organisational religious activity, and intrinsic (or subjective) religiosity. Users are advised not to lump together the scores from these three scales, for reasons already alluded to. In the context of mental ill-health, organisational religious activity – church attendance – may move in the opposite direction to non-organisational religious activities such as private prayer.

For psychiatrists, the heart of the matter is – or should be – the human suffering with which mental disorders are associated. Behind the research, there are hurting and disorientated people who are distanced from their families and communities. The signs and symptoms that psychiatrists attend to in clinical practice are exactly the same things that the world's major faith traditions also attend to. They use different language to talk about them, but they are essentially the same topics. They are experiences of life at its deepest level – beliefs, capacity to find meaning, ability to cope with adversity, behaviour in relationship to others, and so-on. They are the very fabric of religious self-understanding – indeed, of human self-understanding. The notable difference is that most religious people talk about God, and psychiatrists don't do God. However, as we have seen, that is all changing. In any case, God language is not unproblematic even within religion. There are people who are religious who don't do God, and those who do talk about God are often most aware of just how inadequate human language is to the task.

Conceptual boundaries

The World Health Organisation defines mental health not in terms of the absence of signs or symptoms of mental illness but – rather – in terms of capacity to cope with life, and contribute fruitfully, in work and in the wider community (World Health Organization, 2004, p. 12).[2] The WHO does not specifically mention family – which is the context within which I believe the burden of mental disorders is often felt most acutely. In my view, it also over-emphasises work, which may not be realistic for all. Nor does it mention spirituality or religion. However, it does at least define mental health in relationship. Mental wellbeing is experienced in community, not in isolation.

Where, then, does this leave us with regard to our exploration of boundaries? It's hard to imagine how one can erect any kind of clear conceptual fences between spirituality, religion and mental health. Not only are spirituality and religion completely inseparable for many people, but so are spirituality and mental health, as Koenig's research shows. In fact, I'd go further than this. I would say that religion and mental health are pretty difficult to disentangle too. If I stop going to church, and give up on praying because

God seems so far away, that may well be due to a depressive disorder but it is also a big spiritual and religious concern. I can't draw a line between the religious bit of the problem and the psychiatric bit. Unfortunately, that is exactly what mental health professionals have tried to do. Clergy and chaplains deal with the stuff on the spiritual and religious side of the fence, and psychiatrists and mental health professionals deal with the stuff on the other side.

Professional boundaries

Boundaries can be viewed in different ways, and there are different kinds of boundaries. The prevailing view of boundaries in medicine is that you shouldn't trespass across them. This has been reinforced by the serious breaching of major boundaries, for example in cases of sexual abuse of patients by their doctors. We need to be very clear that there are such boundaries, and that they are non-negotiable. However, other boundaries may be more like the kind that you discuss when out walking in the country on a family holiday. You look at the map, and you look at the landmarks around you, and you have a discussion about exactly where the boundaries are. In fact, it isn't so much the boundaries that you are interested in. You want to find the right path. Of course, you don't want to trespass where you shouldn't go, but the purpose of the day out is not to avoid trespassing. The purpose is to find the right path and to go on a journey together.

So, with this in mind, let's look at three of the boundaries that have caused the most concern, at least on this side of the Pond, in relation to spirituality and religion in psychiatric practice.

First, there is the boundary of specialist expertise. Spirituality and religion, it is said, are not the domain of expertise of psychiatrists or other mental health professionals. They have not been trained to deal with such things. Psychiatrists are not so fussy about other boundaries of expertise. They positively love crossing scientific boundaries. Psychiatry has shown itself to be a thoroughly interdisciplinary scientific endeavour. In one of the letters generated in response to Koenig's editorial in 2008, Poole et al. wrote: "Psychiatrists are essentially applied biopsychosocial scientists, who work within a clear set of humanitarian values and ethical principles in order to get alongside service users and facilitate their recovery from a mental illness" (Poole et al., 2008, p. 356–357). So, the real boundary concern seems to be to exclude non-scientific ways of thinking. The danger is that in dismissing anything that is not science, we devalue the things that matter most to those whose care is entrusted to us.

Secondly, there is the boundary between secular and religious spheres of life. This boundary is said to preserve a safe space within which the clinical consultation can occur. It protects patients against religious proselytising, but also against moral judgement. Like the boundary of specialist expertise, this boundary does indeed protect patients in many ways. However, it has one serious problem. Secular space is distrusted by many religious people. It is not experienced as neutral. It is felt – rightly or wrongly – to be negatively judgmental about religion. Given that it is also difficult for many patients to sort out what is religious and what is medical about their struggles with their mental health, this is a very serious failing. They want to be able to talk safely about all aspects of their problem with their mental health professional. Instead, they find themselves afraid of doing so. Such fears are reinforced by labelling of religious talk as "just part of

the illness". When the therapeutic tools of the doctor are all scientific and never spiritual, the patient pretty quickly gets the message.

Thirdly, there is the boundary between personal and professional values. This boundary requires that the clinician keeps their personal and professional values separate. The latter are both allowed and encouraged in the course of clinical work, in support of scientific, impartial advice to be imparted to the patient. The personal domain, however, including the spiritual and religious, is not to be allowed to intrude on clinical practice. As with the other two boundaries that we have discussed, this is in most respects a good thing. Patients need to know whether the advice that they are receiving is offered in a professional capacity, or whether it merely reflects the personal views of the practitioner. However, they do also need to encounter the human face of that practitioner. They need to know – in every encounter with a health professional but especially with a psychiatrist – that they have encountered another person. A clinical encounter is not a friendship, and the psychiatrist should always be aware of the inherent power imbalance, but it must always be a meeting of two human beings who are equal. This fundamental personal equality is – in my view – a spiritual element of clinical practice that has been seriously eroded during my professional lifetime.

So – boundaries of specialist expertise, the secular and professional spheres, and personal and professional values, are all important – but they are important because they need to be explored and mapped, not because every fence has a "No Trespassing" sign nailed to it. In some research that has been ongoing for several years now, Poole and I have been exploring how judgements about good practice work out in relation to specific difficult cases. Curiously, he and I often find ourselves agreeing in practice, even though we disagree in theory! But the boundaries of good practice are not the only boundaries that we have to be concerned about. As I've already indicated, the conceptual boundaries between spirituality, religion and mental health are also important, and they are pretty blurred. By way of example, I'd like to draw to your attention briefly to how this works out in relation to one particular intervention which is usually considered to be spiritual.

Attentive awareness

Mindfulness is a spiritual intervention with a growing evidence base. Mindfulness-Based Cognitive Therapy is now recommended by NIHCE (National Institute for Health and Clinical Excellence, 2009) as an effective method of relapse prevention for adults with depression. Mindfulness has proven itself as an effective tool in the management of addictive disorders and ongoing research shows promise in a number of other mental disorders. Mindfulness meditation has roots within Buddhism, but it has now effectively been extracted from this religious tradition and is employed within a secular psychological framework, often in combination with techniques drawn from cognitive behavioural therapy. Nonetheless, it is widely understood to be a spiritual practice, concerned with non-judgemental attention to an awareness of the present moment. The spirituality of mindfulness is concerned with attention to both inner and outer reality.

Mindfulness has enormous common ground with contemplative practices encountered in almost all of the world's religious traditions. Teresa of Avila, for example, practiced what she referred to as "mental prayer" or, more specifically, the "prayer of recollection". For

Teresa, this was understood as a turning within in order to pay attention to God. It has a theological framework, which contrasts with the atheistic presuppositions of Buddhism. Nonetheless, it is a state of attentive awareness which in practice has much in common with mindfulness. The main difference – if difference there is – is in the Christian presupposition that all of reality (including the inner reality of the human mind) is permeated with the Divine presence. Contemplative prayer is thus, for Christians, an inter-personal encounter with God. Similarly, Islam, Judaism, Hinduism, and many other religions, have contemplative traditions which, share this transcendent perspective. Mindfulness and contemplative prayer are at once spiritual, religious and psychological practices, and they have measurable impact upon mental health.

Taking all of this into account, I think that Koenig (2008) is correct to say that we have a hopelessly tautological understanding of the relationships between spirituality, religion and mental health, which may be useful for clinical work but which undermines any possibility of research. As he has illustrated in a series of diagrams in his 2008 paper in *Journal of Nervous and Mental Disease*, not only do our conceptual circles of spirituality and religion overlap, but they have grown to encompass much of what we understand to be mental health. Everyone is spiritual now, and there are no distinct groups left for research to compare.

Whilst I largely agree with Koenig, I want to go even further. Religion and mental health share more common ground than his diagrams allow. If we are measuring mental health on the basis of traditionally conceived positive and negative indicators of mental wellbeing then everything is hopelessly mixed up. If he had represented mental health as a circle, rather than as a series of boxes, and if he had taken this common ground into account, we would have three largely overlapping circles. What is needed is a more relational and vocational approach to mental health, something more similar to the WHO definition.

Mental health, spirituality and religion are all about living in relationship. The large circle within which our relationships are defined is not – as the WHO seem to think – "the community". There is something bigger than this – something transcendent. Within this context, spiritual and mental wellbeing are marked by our willingness or ability to be attentive to the things that matter. So, I'd like to suggest that mental health is an attentive awareness to self and others in the context of transcendence. I think this is also a good definition of spiritual health because I'm really not convinced that the boundary between spiritual and mental wellbeing allows us to define the one in separation from the other. It may also be a good definition of religious health, although I think that we'd all want to translate it into the languages of our own traditions.

Because mental and spiritual wellbeing are primarily about this relational attentiveness, and not about symptoms, some people with psychiatric diagnoses may paradoxically be more spiritually and mentally healthy than some people without a diagnosis. This does not mean that diagnoses are not important, but it does mean that diagnostic boundaries may not be the ones that best define spiritual wellbeing.

The boundaries of psychiatry

Going back to our professional boundaries … Where does all of this leave us now?

Some things clearly are never acceptable. Proselytising either reflects a lack of attention, or else the wrong kind of attention, to one's relationship with self and others. I am

well aware of the missionary imperative within both Christianity and Islam, but the mission of God in the world is not furthered by taking advantage of the vulnerability of others in times of crisis or illness. In any case, does this kind of proselytising really have anything to do with the mission of God – or is it just an attempt to give attention to something in the other that really needs attention within oneself? Perhaps the "No Trespassing" sign really needs to be nailed to the projective defence mechanisms that invade the lives of others in order to reduce our own anxieties and insecurities?

Most other things, I think, are about a courageous and wise willingness to sometimes cross boundaries in order to explore and map them better. We need to pay attention to one another as we elaborate and debate our different ideas about what spirituality is and what good practice looks like. I have learned a lot from my atheist colleague Professor Poole, not to mention many other members of the SPSIG whose spirituality and religious faith is different to mine. In some ways, our common vocation as psychiatrists may shape us more than our identities as Atheist, Christian, Muslim or Hindu, but it will never erase our spiritual or religious identity. It is incumbent upon us, for the benefit of our patients, to give attention to exactly what it is that we do and do not agree upon. We need to give attention together to the immanent and transcendent concerns of our profession.

Simone Weil, the French philosopher and mystic said that:

> Attention, taken to its highest degree, is the same thing as prayer. It presupposes faith and love. Absolutely unmixed attention is prayer. (Weil, 1952, pp. 105–106)

As psychiatrists, we are called to give this kind of attention to people when they are hurting, wounded, broken and confused. This is a high calling. It is a spiritual vocation. For many of us, it is also our religious vocation. Spiritual, religious and mental wellbeing depend upon this kind of attentiveness. I cannot be a good Christian, or a good psychiatrist, without it.

Research is also, in a different way, a giving of attention to these things. The rigidly immanent frame of much scientific research is a concern. We need much more interdisciplinary engagement with theology, anthropology and philosophy. Exactly how does the attentive, or contemplative, awareness that is at the heart of spiritual and mental wellbeing help us to flourish? What does the inattentiveness of those who are "not flourishing" look like? Are different kinds of attentiveness associated with extrinsic and extrinsic religiosity?

In conclusion

Things have changed a lot since Freud (1961) wrote *The Future of an Illusion*. The boundary between religion and psychiatry is now not so much a beachhead as a moving shoreline.

In *Civilisation and its Discontents*, Freud (1930`/2010) takes up the idea of an "oceanic" feeling, an idea presented to him in a letter from his friend Romain Rolland. Freud could not identify with this oceanic feeling himself, but he did engage with it. It is, he wrote,

> a feeling which [Rolland] would like to call a sensation of 'eternity', a feeling as of something limitless, unbounded — as it were, 'oceanic'. This feeling, [Rolland] adds, is a purely subjective fact, not an article of faith; it brings with it no assurance of personal immortality, but it is the source of the religious energy which is seized upon by … Churches and religious systems … (Freud, 2010, p. 11)

This is what we call spirituality. Along with our colleagues in the APA and the WPA, and in dialogue with others, I trust that the SPSIG can look forward to making even more progress in exploring the shoreline of this ocean in the next 20 years than it has done in the last twenty.

Notes

1. In particular, there is a selective emphasis on North American and European literature and much of the research referred to has been conducted on Caucasian, largely Judeo-Christian, populations. This reflects a wider bias in the evidence base.
2. For a recent attempt to define mental health in a more inclusive way, see Galderisi et al., 2015. For an attempt to define health in such a way as to include a spiritual dimension alongside mental, bodily, social, and other dimensions see Huber et al., 2016.

Disclosure statement

The author is a past chair of the Spirituality & Psychiatry Special Interest Group at the Royal College of Psychiatrists.

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