

Addressing Spiritual Issues in Psychiatric Treatment

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Psychiatry and spirituality have had a rocky relationship. In medieval times they were intimately connected, with religious concepts used to explain mental illness and religious activity prescribed as cures for mental illness. [1] Sperry confirms this, stating that “psychological and spiritual issues were largely the domain of priest-healer until the 18th century.” [2] The initial split between religion and psychiatry may have occurred in the late 18th century. In 1775 a contest between a physician Messner and an exorcist Gassner to treat the same patient resulted in Messner’s triumph and the split of religion from psychiatry, per Sperry. [2] Sigmund Freud took a strong stance against religion [3], furthering this split. Albert Ellis and the school of Rational Emotive Therapy continued this trend, holding religious belief as psychopathologic [4]. Religious thinkers have encouraged this split as well, some going to the extent of discouraging parishioners from receiving or practicing psychoanalytic treatment. [3]

Recently, psychiatry has shifted back to a more neutral, and at times positive attitude towards religion and spirituality. Rather than viewing religion as psychopathologic, it is acknowledged as a normal, and even beneficial part of human life. [4] Sperry points to the addition of the DSM-IV category “Religious and Spiritual Problem”, and the 1995 addition of the requirement for spirituality curriculum in all psychiatry residency training programs as signs of this shift. [2] This overall shift from antagonism to respect in psychiatry has been acknowledged by many authors. [2], [3], [4], [5]

Spirituality is a central part of many patients' lives, [2] though the degree and practice of spirituality varies widely. [6] Psychiatrists, on the other hand, are less religious than the general public, their patients, and other physicians [3] which may add to the historical tension between psychiatry and religion. However, the fact that psychiatrists are more willing to discuss spiritual issues than other physicians despite being less religious personally than other physicians [3] may be yet another sign that the historical antagonism between religion and psychiatry is resolving. There are signs that patients welcome this rapprochement. In Curlin's survey of psychiatrists, 46% of patients seeing psychiatrists "often or always" mentioned spiritual issues in treatment, and another 46% "sometimes" mentioned spiritual issues in treatment. [3] These results suggest that many patients wish to address spiritual issues within the context of psychiatric care. This paper explores how to do so in an ethical and therapeutic way.

Research literature suggests that spirituality has an overall positive association with both physical and mental health. [1], [7] The positive impact on mental health may be related to spiritual beliefs offering hope and meaning in the midst of illness. [8] , [9] Another aspect of spirituality that may have a positive impact on mental health is the faith community providing practical support and stability to patients. [8] Psychiatrists seem to generally acknowledge this positive impact. In Curlin's survey of 100 psychiatrists, 76% felt that religion had a positive influence on health, 21% felt spirituality has an equally positive and negative impact, 2% felt it was a generally negative influence, and 1% felt it had no influence. [3]

Potentially negative impacts of spirituality on mental health need to be acknowledged as well, however. For some patients, religious involvement "contributes to maladaptive behavior and pathogenic modes of psychological functioning". [8] Religious life may even be the root of some patients' problems "such as a discrepancy between parental or communal religious

expectations and the patient's expectations, or abusive relationships with religious institutions or clergy". [4] Certain religious groups discredit psychiatric care and may actively discourage members from seeking psychiatric help because of concerns of social stigma or a fear of decreased religiousness. [4] The American Psychiatric Association also acknowledges a potential lack of trust from patients in some religious groups if the psychiatrist does not share the same worldview or is not endorsed by their religious leaders. [9] Perhaps because of Freud's statements about the infantilism of religion, religious patients may avoid psychiatric treatment because of the fear that the psychiatrist will seek to alter their spiritual beliefs. [10] Even though psychiatry has moved away from Freud's perspective, "hesitations regarding psychotherapy and the use of medication persist in a variety of spiritual and religious traditions." [10] Thus, in some patients, spiritual involvement may directly worsen mental health or lead to worsened pathology by causing the avoidance of psychiatric care.

It is in this complex milieu that psychiatrists attempt to find their own way of addressing spiritual issues in treatment. There is a wide range of approaches, ranging from "total exclusion of concern about, or even inquiry into, patients' beliefs" to addressing spiritual issues directly in treatment. [6] As Meador points out, "efforts to establish universally applicable approaches to the incorporation of religion and spirituality into the practice of psychiatry and health care are inconsistent with our commitment to respecting the cultural and religious particularity of both patients and clinicians." [10] Thus this paper will seek to explore different approaches in an effort to help clinicians to pick an approach that is the best fit for them and their patients.

In exploring spiritual issues in psychiatric treatment, it is helpful to examine patient expectations. Different patients may expect completely different approaches to addressing spirituality in psychiatric treatment. Some patients expect the psychiatrist to directly address

spirituality to the extent that they "wonder if the psychiatrist will undermine or compete with their minister or priest for spiritual leadership." [6] Other patients may expect the psychiatrist to dismiss spirituality as a concern, assuming "that the psychiatrist will embody the clinical-scientific disinterest in religion often exemplified by their internist or family physician". [6] Patients with an expectation of clinical disinterest may believe inquiry into spiritual issues is outside the psychiatrist's purview and may become suspicious of a proselytizing motive if spirituality is discussed. [6] Further, religious patients may misconstrue inquiry as a challenge to their beliefs and answer defensively, while non-religious patients may misconstrue inquiry as a criticism of their nonspiritual or antireligious ideas. [6] Due to the historical tension between religion and psychiatry, some patients may fear the discussion of spirituality because of fears of being misunderstood or "that the psychiatrist has a negative view of religion and may attempt to modify the patient's religious commitments." [4]

It is understandable that some psychiatrist choose to avoid this potential minefield by avoiding discussion of spirituality with their patients. In Curlin's survey of 100 psychiatrists, 7% of psychiatrists "sometimes" tried to change the subject away from spiritual and religious issues in a tactful way, while 2% of psychiatrists did this "often or always" when patients bring up spiritual issues. [3] A similar approach would be to acknowledge a spiritual problem as important, but to "focus only on its emotional aspects, avoiding any discussion of spiritual and moral issues." [7] Many clinicians choose to address spirituality to a greater extent than these two approaches. The most basic level of addressing spiritual issues is to proactively assess the extent of impact of spirituality on a patient's life. The requirement for spirituality curriculum in all psychiatry residency training programs mentioned previously is a sign that there is now a general expectation that psychiatrists be able to assess their patients' spirituality on some level.

Josephson takes it a step further and suggests that “several routine screening questions about religion and spirituality should be part of the psychiatric assessment.” [7] Through this spiritual screening, clinicians are better able to assess whether spirituality may be an important subject to address in treatment.

Based on the spiritual assessment, clinicians can then choose the most appropriate approach to addressing spiritual issues based on patient preferences and expectations as well as clinician comfort and expertise. One possible approach is to “clarify moral conflicts as important and in need of serious attention in their own right, going beyond the psychological interpretation.” [7] This approach leads to a deepened understanding of the pertinent spiritual issues and typically leads to the clinician “assisting the patient with finding resources for further help (e.g. hospital chaplain, pastor, priest, rabbi, or religious community)”. [7] Some clinicians choose a slightly different tack and work to distinguish the emotional and spiritual aspects of the presenting problem and explore these aspects in relation to each other. [7]

Certain clinicians may choose to “address the spiritual problem directly within the treatment through the use of a shared religious or spiritual orientation.” [7] This approach and its implications are somewhat controversial. One implication of this approach is that the clinician has made a decision to reveal his own spiritual orientation to the patient. Self-revelation alone is a controversial issue. In his survey of 121 psychiatry residents from 5 psychiatric residency programs, Waldfogel reports 63% of residents disagreed with the statement that it is “acceptable to reveal religious beliefs” to patients, with 24% “not sure”, and 12.4% believing it to be acceptable. [11] Curlin’s survey of 100 psychiatrists revealed that 20% felt it was “never” appropriate for a physician to talk about his or her own religious beliefs or experiences with a patient, 32% believed it appropriate “only when the patient asks,” and 48% believing it was

appropriate “whenever the physician senses it would be appropriate”. The discrepancy between psychiatry residents and psychiatrists may be reflective of the context and phrasing of the particular survey questions as well as different stages of training and experience. Regardless of this discrepancy in results, it is clear from these surveys that some psychiatrists object to the revelation of personal spiritual beliefs to patients.

Despite these objections, some authors argue clinicians may actually be obligated to reveal their personal spiritual beliefs in certain circumstances. Thurrell suggests that if patients question the psychiatrist about his personal spiritual orientation as a result of the psychiatrist asking the patient about spirituality, the patients "deserve a brief acknowledgment of the psychiatrist's orientation." [6] Meador goes further, arguing that if psychiatrists choose to draw from their personal spiritual beliefs and practices when discussing spiritual issues with their patients, they may be obligated to adequately reveal their personal spiritual beliefs in order to fulfill the expectation of informed consent, since the clinician's personal beliefs may influence the treatment. [10] This self-disclosure would be especially important if the clinician has identified personal spiritual biases that may influence the way he conducts treatment. Unfortunately, adequate disclosure is not possible if the psychiatrist himself is not aware of his biases. Psychiatrists who hold strong personal spiritual beliefs may be "so consumed by their personal religious convictions that they have a limited capacity to appreciate the significance of the potential alternative faith commitments of their patients." [10] On the other hand, "the explicit avoidance of religion as a conscious issue of exploration in the personal lives of some psychiatrists or therapists may have left them particularly vulnerable to a lack of insight regarding their own spiritual biases." [10] Either of these cases may lead to treatment that is skewed by the psychiatrist's biases, leading to unintentional harm to the patient.

Assuming that a psychiatrist reveals his personal spiritual orientation, he may choose to use shared spiritual orientation with a patient to incorporate spiritual practices into treatment. An example of this practice is a psychiatrist who chooses to incorporate prayer into the treatment of patients who have a shared spiritual orientation. This practice appears to be even more controversial than clinician disclosure of personal spiritual beliefs. Thurrell “disagrees with the direct use of religious practices admixed with approved psychiatric treatment methods”. [6] Data from Waldfoegel’s survey of psychiatric residents suggests most psychiatric residents would agree with Thurrell’s statement, with 69.8% disagreeing with the statement that it is “acceptable to pray with patients”, 21.0% not sure, and 9.2% believing prayer with patients to be acceptable. [11] Curlin’s survey of psychiatrists reveals a more distributed spectrum of opinions, with 34% of psychiatrists agreeing that it is “never” appropriate for a physician to pray with a patient, 34% believing it appropriate “only when the patient asks”, and 32% believing it was appropriate “whenever the physician senses it would be appropriate.” [3]

Interestingly, Curlin’s survey also reveals that though 66% of psychiatrists believe praying with a patient is appropriate in certain circumstances, 94% of psychiatrists “rarely or never” pray with patients, while 5% “sometimes pray with patients, and only 1% “often or always” pray with patients “when religious/spiritual issues come up in discussions with patients.” [3] These survey results may be skewed by psychiatrists under-reporting the use of prayer in clinical practice because of fears of criticism by fellow psychiatrists. Even with the possibility of under-reporting, the results of Curlin’s survey still suggest that while most psychiatrists feel prayer with patients is not absolutely contraindicated in clinical practice, an overwhelming majority rarely or never choose to pray with their patients. Significant potential pitfalls need to be avoided in order to address spirituality ethically. These pitfalls may be why

some psychiatrists object to spiritual discussions and practices in treatment, and why so few psychiatrists incorporate prayer despite the majority believing it is not contraindicated in treatment.

One potential pitfall in addressing spiritual issues in psychiatric treatment is the abuse of the power differential inherent to a therapeutic relationship. Meador discusses how this power differential is accentuated by the “historically and socially constructed power dynamics inherent to religion and spirituality” when the psychiatrist chooses to address spiritual issues in treatment.

[10] In order to avoid abuse of this power differential, Meador suggests clinicians include only what is internal to the patient’s personal tradition and narrative in addressing spiritual issues.

[10] By avoiding anything external to the patient’s own tradition and narrative, clinicians can “prevent subtle shifts into interjecting the religious traditions or beliefs of the clinician into the clinical context as a corrective to the implied inadequacy of the patient’s spiritual life”. [10]

Meador notes that though this guideline may be viewed as constraining by some, it actually allows “considerable latitude for the patient and clinician who are closely matched in religious practices, while offering a protective measure to provide structure within a treatment process...”

[10] Meador distinguishes “honoring and clinically maximizing the inherent potential within the spiritual commitments internal to the patient’s personal narrative” from “a clinician’s presuming religious prescriptive prerogatives that are not contextually derived,” the former being potentially therapeutic and the latter being ethically problematic. Overall, Meador’s guideline “allows for the inclusion of religious and spiritual issues without jeopardizing the clinical confidence of patients from minority religious perspectives or traditions that do not match those of the clinician.” [10]

When applied to spiritual issues, cognitive therapy may be especially vulnerable to potential abuse of power because "the adjudication of what constitutes a cognitive distortion is a culturally dependent judgment and spiritual issues are particularly vulnerable to misinterpretation." [10] Clinicians need to tread carefully in utilizing cognitive therapy techniques in addressing spiritual issues to ensure they include only what is internal to the patient's personal tradition and narrative. Eichelman describes his experience using cognitive therapy in "encouraging patients, when appropriate, to alter their faith and move from allegiance to a guilt-evoking faith and belief in an exclusively punitive God toward a less punitive belief system more fully embracing such elements as 'forgiveness' and 'grace'" [12] Eichelman goes on to say that "such a transmuting of beliefs may allow patients to retain elements of their childhood faith, while cognitively altering these beliefs enough so as to allow continued practice or emotional support." [12] In this example, if this patient originally believed in a God that was forgiving, but because of mental filtering common in depression the patient focused solely on the punitive aspects of God, Eichelman's intervention would have been internal to the patient's personal tradition. If, however, Eichelman had encouraged the patient change beliefs to a different tradition and a different God in an effort to alleviate the patient's suffering, he would have gone external to the patient's personal tradition and would in that case be vulnerable to ethical rebuke.

The power differential in therapeutic relationships can also be potentially abused in either covert or overt proselytizing. Through subtle suggestions that the patient's choice of belief system is the cause of his problems, or even overt advice to switch faith traditions, psychiatrists may be tempted to exploit the power differential for their own gain. Psychiatrists may do this to gain favor in their own personal religion or do this in unconscious effort to use the clinical

context to work on their own personal spiritual journey. [10] This troubling potential abuse of power may be why some psychiatrists object to addressing spirituality in psychiatric care. Regardless of motivation, psychiatrists should never "impose their own religious/spiritual, antireligious/spiritual, or other values, beliefs and world views on their patients." [9]

For psychiatrists choosing to incorporate spiritual advice or practices in their clinical practice, it is also important to ensure spiritual advice or rituals are included only as an adjunct to generally accepted standard treatments, never as a replacement. The American Psychiatric Association (APA) explicitly addresses this issue, stating "clinicians must not offer religious/spiritual commitments or ritual as a substitute for professionally accepted diagnostic methods or therapeutic practice." [9] Among psychiatrists who incorporate prayer and other spiritual practices in their clinical practice, it seems that this rule is generally followed. Baetz reports that in these psychiatrists, spiritual practices were not recommended to the exclusion of medication or insight-oriented psychotherapy. [13] Rather, prayer and Bible reading were prescribed as adjuncts to traditional treatments, and more likely to be prescribed when clinician and patient were of like faith. [13]

It is also important for psychiatrists who address spiritual issues in treatment not to demand that patients discuss spiritual matters, even if those spiritual issues are affecting their psychiatric health. As discussed earlier, different patients have different expectations of what is appropriate to discuss within psychiatric treatment. While some patients welcome the opportunity to discuss spiritual issues with their psychiatrist, some patients prefer to address spiritual issues in a religious context outside of psychiatric treatment. Psychiatrists should keep this in mind and not conclude that patients' refusal to talk about spiritual issues is "prima facie evidence of avoidance." [4]

While there is evidence for potential benefit when psychiatrists' and patients' beliefs are closely matched [10], psychiatrists should not assume that patients prefer clinicians from the same faith background. Lawrence points out that "a patient with feelings of guilt might be wary of a psychiatrist of the same religious denomination." [5] Patients who have experienced abuse from members or leaders of their religious tradition may actively avoid psychiatrists from the same tradition to avoid a repetition of the abuse. Another pitfall of shared religious background between patient and clinician is that the clinician "may unwittingly assume a greater commonality of values between doctor and patient than actually exists." [4] This may lead the clinician to not ask about deviant or antisocial behaviors or attitudes, and also may place expectations of conformity upon the patient. [4]

Besides the potential pitfalls mentioned, there are other obstacles to addressing spiritual issues in treatment. The biggest obstacle cited by psychiatrists in Curlin's survey was insufficient time, with 35% noting this as a factor that discourages them from discussing spirituality with patients. [3] This obstacle is unlikely to change in today's managed care environment, and one that is beyond the scope of this paper to address. 25% of psychiatrists surveyed by Curlin cited insufficient knowledge/training as a barrier to discussing spiritual issues with patients. [3] Historically there has been little didactic or supervisory training focused on addressing spirituality. [11] Waldfogel found that residents who received some training in addressing spiritual issues felt more competent to address these issues with their patients than residents without such training. [11] This finding supports the continued inclusion of spirituality curriculum in residency training. This training can help psychiatrists obtain practical tools and gain a feeling of competency in addressing spiritual issues that arise in treatment.

In Curlin's survey, psychiatrists also cited "concern about offending patients" (25%), "general discomfort" (13%), and "concern that colleagues will disapprove" (3%) as barriers to addressing spiritual issues in treatment. [3] Training on how to professionally and ethically address spiritual issues in psychiatric treatment, including education on common pitfalls and ways to avoid unethical behavior may assuage discomfort and concerns about offending patients and colleagues. Of note, even with adequate training, psychiatrists may fear not being an expert on topics of spirituality. It is unreasonable to expect a psychiatrist to be knowledgeable about all aspects of a patient's chosen spiritual practices. Thus Blass suggests that involvement of reliable informants, such as clergy and religious leaders, may be helpful when clarification is necessary. [4]

Spirituality is an affect-laden and sensitive topic for patients and clinicians alike. Therefore it is not surprising that addressing spiritual issues in psychiatric treatment is complicated and fraught with potential pitfalls and dangers of abuse. While this may lead some clinicians to avoid spiritual topics in treatment, addressing spiritual issues can be a "potentially profound means of caring for patients." [10] Training and education appear to be keys to addressing spiritual issues in a therapeutic and ethical way, and thus deserve greater attention and funding in the future.

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