

‘God’s place’ in Psychiatry - Spirituality in psychiatric education and training

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As I cast my mind back to my early years, I believe my childhood strategy in tackling the experience of the world was in searching for points of reference, discovering what was within reach and outside reach, within control and outside control. In the ‘outside reach’ of my experience there were many unanswered questions, and many remained as such as years went by and more mature times approached.

I recall for example that my parents gave me a sense of security that was eroded by my gradually discovering that they had limitations and did not rule the world.

Instructed to follow example, I felt naturally driven to equal that dimension with the religious practice of my parents, struggling with the necessity to accept the unproven in an act of what they called ‘faith’. Later, as a medical student, I became increasingly aware of the limits of human science, just like the limitations I had discovered in my parents. The struggle diverged onto excluding – or if feasible including – what was ‘outside empirical reach’ into one’s scientific education.

In this search, what seemed to remain ‘empirically acceptable’ to medicine had to do with ethics, morality and conduct, coinciding with behavioural and sociological constructs. These appeared to arise from millions of years of evolution in order to meet the demands of evolving societies and civilizations. Some have in fact proposed that religion developed in response to increasing life spans, establishing a moral code. This would include the generations of older elderly in society in a meaningful way.

Historically, therefore, moral orientation emerged from an original spiritual quest. This gave life to enlightenment, doctrines and religions that have covered the globe and whose rituals are still practiced today. And it is in this world medicine is practiced, where God’s place is all too often where the doctors do not help any more, in a chapel of rest.

The chasm widens even more in psychiatry, where until recently trainees were not encouraged to look at this side of human behaviour. In fact there seems to have been a tacit understanding that one would place oneself at the eccentric end of psychiatric practice and become a kind of professional freak if one ever thought of carrying out research in the subject. Religion was deemed to be bad for one’s career and in consequence ignored. After all, eminent psychiatrists had declared religion a sign of emotional imbalance, a psychosis, a regression of the ego, a type of pathological thinking.

Around the middle of the last century, psychiatry edged more and more towards a value-free status, dispensing with the bonds of moral judgment. But it also finally aligned itself to powers of ‘normalization’ and ‘standardization’, which in sociological terms may create extreme opportunities for being used politically to exert control over people, nations. One of the most tragic examples of political manipulation of psychiatry lay in the holocaust of mental patients sanctioned by German psychiatrists in Nazi Germany.^{1,2}

Let me put to you that spirituality encompasses a universal characteristic of the human mind. The Latin word ‘spiritus’ refers to that part of oneself that guides the mind that in turn guides behaviour. Human minds are unified by the conscious perception of existence and it is conceivable that at the beginning of one’s life the mind might hold only an ability to develop a spiritual dimension. This may occur in response to automatic existential questions: ‘where do we come from? Why do we suffer? Why do we die?’ Culture and formal religions will address the need to explain conduct, morality, rituals

and superstitions.³ Spirituality embraces the intimate experience of transcendence and the social experience of religions and religious practices, a range of developmental and cultural psychosocial dimensions. Categories of spirituality have been broadly defined as the beliefs in a power greater than oneself, purpose in life, faith, trust in providence, finding meaning in suffering, gratitude for life, life as a gift, and behavioural expressions such as prayer, meditation, group worship. These categories reflect optimism and psychological health.⁴

The question arises, 'is spirituality at the roots of all happiness?' Happiness is a highly individual concept, and perhaps the term contentment is more acceptable, contentment in integrity, individual human integrity.

Does spirituality have any relevance to healing and treatment?

The evidence is that spirituality has much relevance. Spirituality is relevant to outcome in chronic pain, diabetes, haemodialysis, malignancies, fractures, cardiac surgery, AIDS and other medical and surgical pathologies.

As an Old Age Psychiatrist, I observe much 'returning to God' in my patients. Resumption of spiritual aspects of behaviour in later life is understandable. The process of ageing is ultimately beyond our control and arouses anxieties and emotions in the attempt to procure the re-establishment of a fading locus of control. In existential terms, spirituality may serve the purpose of finding connectedness and endurance at the end of one's existence. It preserves self-esteem and individual integrity and gives opportunities to benefit from an extrinsic social network.

Spirituality takes diverse forms, depending on gender, culture and ethnicity. Particularly in elderly women, spirituality is accompanied by acts of ritual worship.

Current evidence seems to suggest that religion and spirituality have an important role in the health of the elderly. See, for example, those in institutional care, or the correlation with survival, with behaviour conducive to health, coping with bereavement, or the protective effect against depression, suicide and the role of spirituality in dementia care.

Is there a place for spirituality in psychiatric training?

There is no doubt that psychiatrists neglect spirituality. The modern standard psychiatric textbook may contain a few references to religious matters, relating to conversion and dissociative disorders, for example, as aberrations of religious ceremonies. Or a mention may be found in obsessive disorders, where the obsession is in fact the religious doubt over God's existence.

Even in Transcultural psychiatric training, where one would expect more specific instruction over the teaching of morality and spirituality of certain cultures and ethnic groups, the dearth of information is mesmerizing. Yet in everyday practice we come across patients from ethnic minorities, and especially in the older generations one has experienced the polite but stern refusal to accept psychiatric help. It is reasonable to assume that the reason for this is that the psychiatrist is seen as the bearer of 'shame' or more so someone who cannot speak the 'same language'. Translation is not as crucial as the real understanding of moral and cultural make up. Effective work can only occur when communication is clear and respectful of the patient's fundamental beliefs and attitudes.

The majority of psychiatrists in the UK do not believe in God and papers on religion or spirituality tend to come from disciplines other than psychiatry. In fact, religion and psychiatry have enjoyed a polarized relationship for a very long time. Despite the individual belief of the psychiatrist, however, in reality patients value spiritual matters and suffer the psychological consequences of conflicts with moral and spiritual connotations.

Ignoring these factors can lead to unsatisfactory clinical management, even making a wrong diagnoses.

Patients appreciate being asked about their spirituality, even if they do not subscribe to a formal creed. A USA study showed that among over 200 patients 77% would like doctors to consider their spiritual needs, 37% would like to discuss these. Also, 48% expressed the wish that the physician would pray with them. In contrast, 68% of physicians in this study had not considered or discussed any matter relating to spiritual needs with their patients.⁵ Data from patients attending a rehabilitation centre also confirmed that over half (54%) would like to receive spiritual support, whilst in about 73% of cases no member of staff had mentioned spiritual requirements.⁶ In another study 22 patients who had survived a recent life threatening illness were asked to comment on their experience. Their comments could be grouped in categories, including spirituality, prayer and rapport with the doctor. Faith was important in psychological healing and patients were happy to talk about spiritual matters with their physician. However, the physician was expected to have the required understanding disposition.⁷

A study of elderly in-patients in the UK showed that the input of the chaplain was much valued.⁸

The evidence is incongruent. Psychiatrists neglect to assess the spiritual dimension of their patients' psychopathology but they equally feel that spiritual matters are relevant to psychiatry. A study of 208 Australian old age psychiatrists yielded interesting results. 43% had no religious affiliation, 25% attended monthly services, 85% believed that there is a link between religion and mental health and 34% had never referred patients to a pastoral counsellor.⁹

Placing spirituality in a psychiatric frame

When faced with a stressful situation, individuals change the way in which they behave. They adapt their behaviour to the stressful situation in a way that will allow them to cope longer, and in these moments spiritual matters come to the fore. Their reappraisal looks outwards, to expedients enabling practical coping mechanisms, but also inwards, where moral and spiritual resources may be found to provide back up at a time of struggle. 'Why is this happening? Why to me? What does it mean to me?' These are the key questions asked by those who suffer, the search for meaning allowing space for spiritual growth, attempting to compensate the weakening effect of the 'insult', a trauma or disease, indeed a mental illness.

An individual facing a critical situation may seek for solutions outside his sphere of control. Spirituality may produce a dimension where control is handed over and at the same time shared with the transcendent, creating moral strength and detachment. Individuals reviewing their lives may decide to change their habits into healthier ones, possibly more compatible with their moral beginnings. They may reorganize their priorities.¹⁰ Where financial concerns and career may have had primacy, health, family values and support may for example come in their place.

Moral growth crisis also relates to those individuals who do not subscribe to a religious group. In fact, the 'god' may not have a name or be culturally identifiable. Religious principles may be replaced by moral reflection. In today's worlds, theophanies abound, minor and major sects, philosophical and heuristic ideologies. This is a particular phenomenon of western spirituality. Here major monotheistic religions continue to suffer historical erosions caused by the irreverent assault of materialism. Hence, as faith and dogmas may be disowned or forgotten at an individual level, the cultural principles of conduct underpinning Christianity, Judaism or Islam for example, will remain at the core of the moral philosophy of individuals.^{11,12} And it is from any

group that psychiatric patients may arise, with their individuality, their background and their morality.

Spirituality is therefore bound to be relevant to the phenomenology of psychosis, affective illness, neurosis, to the coping with stress, bereavement, disease, to the management of anxiety and depression, of suicidal behaviour, to the care of the elderly and their carers.

Ethical aspects

The fundamental questions here appear to be: 'is concern with the spiritual a job that should be done by the chaplain? Should professional roles between chaplains and physicians be kept separate? When is spirituality/religion dangerous and should not be used in treatment plans?'

The argument for keeping professional roles as distinct is important, especially in psychiatry. Here the psychiatrist instructs and reviews comprehensive care plans in which the contribution of the chaplain could ideally to be seen within a multidisciplinary context. The psychiatrists should not be required to make their beliefs – or lack of them - manifest and must ensure neutrality in their understanding, nor should they lead prayers with patients. Prayers must be led by a dedicated church minister.

Some religious beliefs may clash with prevalent morality and ethical judgment. There are instances of refusal of treatment by competent adults on the grounds of religion, and the possibility of tragic consequences must be borne in mind. Asser, for example, described a series of 172 children who had died after their parents had declined standard treatment because they relied on faith healing.¹³ Psychiatrists may be called to give an opinion in cases where psychopathology in the patient affects moral decisions, such as in maintaining pregnancies, supporting requests for termination, decisions to refuse treatment for terminal illness, or requests for the withdrawal of life support. In these cases consideration of legal frameworks and of patients' cultural and spiritual background becomes essential in discerning a balanced view.

What about the actual structure of training?

Psychiatric training in the USA has incorporated the notion of professional respect for patients' beliefs and religious practice. Here instruction is given that diagnosis and treatment at odds with individuals' morality should not be used. The DSM-IV includes a category of 'religious or spiritual problems'.

The Association of American Colleges Medical School Objectives Project indicates that doctors should '...seek to understand the meaning of the patients' histories in the context of the patients' beliefs, and family and cultural values'.¹⁴ (AAMC, 1998) and in the United States medical schools are now conducting courses on spirituality.¹⁵ This return to spiritual matters finds its confirmation in the increasing literature on the subject published in the USA.

As for the UK, Introducing spirituality in the post graduate curriculum of future psychiatrists will not only involve the training of younger psychiatrists but also the instruction of professionals imparting and supervising that training. Questions to be addressed are: 'How is the assessment of mental state to incorporate spirituality in a systematic and professional way? How is the professional to address ethnicity from a spiritual viewpoint? How is the structure of multidisciplinary work to include consideration of spiritual issues?'

Instruction for psychiatrists could start from supervised re-visiting of personal attitudes to spirituality and gaining insight into one's beliefs (or lack of). This would be complemented by being trained to seek the spiritual reference set of patients, done in a

dispassionate and non-judgmental way, and without compromising principles of moral ethics.

At a clinical level, a simple method of addressing spiritual issues in the assessment of mental state has been suggested by Puchalski.¹⁶ She quotes four questions: 1) Do you consider yourself spiritual or religious? 2) How important are these beliefs to you, and do they influence how you care for yourself? 3) Do you belong to a spiritual community? 4) How might health care providers best address any needs in this area?

Questions like these could be simplified for those with lesser verbal ability and in those with cognitive dysfunction.

Courses in the cultural aspects, morality and religious traditions of ethnic groups could become part of training, as well as in aspects of pastoral counselling. These courses could call on the collaboration of religious ministers from identified groups in the community and from hospital chaplaincies. Equally, training and education in psychiatry could be made available to pastoral counsellors.

Maximising the contribution of chaplains depends on dealing with a number of factors. Some chaplains might have doubts into the fitting of their role within psychiatry. There may be understandable wariness over role diffusion for both parties. Crucially there must also be availability of time and manpower.

An initial step towards a more systematic development of this therapeutic collaboration would be in looking at the chaplain in a consultative role, as someone who can advise and educate on spiritual implications of certain types of belief. Spiritual counsellors would also naturally wish to maintain their professional independence and right to confidentiality on issues the patients may not wish to divulge to other members of the team.

A vision for the future may be that of spiritual advisors attending case conferences and carrying out joint community visits with members of mental health teams. The spiritual advisor could also advise as to when spiritual intervention may not be indicated or be potentially counterproductive to the management of specific cases. These may for example include severely psychotic individuals, those who express aversion to spiritual support being made available or those who do not wish to discuss matters concerning their spirituality or morality.¹⁷ Non believers may in fact fulfil 'spiritual needs' in different ways, through reading, music, arts, relationships, employment and clinicians should be aware of this possibility.

A proposal

The responsibility of psychiatric educators is to teach and train doctors to consider biological, psychological and sociological factors responsible for psychopathology. The clinical psychiatrist's reference set is in 'normal schemata' and these are challenged by patients' mental illness. Here one deals with individuality rather than standardization, quality rather than quantity, and on a one to one, the clinician's psyche is also being tested versus that of the patient seeking help. The psychiatrist should seek an in-depth knowledge of his motivational moral attitudes and of his accepted or rejected spirituality before embarking onto dealing with the same in individuals who are vulnerable by virtue of their illness. A non-judgmental attitude can arise out of self-reflection and acceptance of the wholeness and uniqueness of individuals.

A spiritual dimension, from subliminal to overt, applies to diverse life phases in different degrees. Pathoplastic and healing effects of spirituality become more critical at especially introspective periods, statistically challenged by disease, frailty, the final

resurgence of unresolved conflicts or indeed the inability to articulate one's unmet needs.

A proposal for teaching and training is therefore put forward, based on the following: the acknowledgment of possible spiritual dimensions in oneself and others, the deeper understanding of cultural and trans-cultural origins of patients, the readiness to ask a 'sensitive' question concerning spiritual outlook and to follow the therapeutic lead if one presents, the readiness not to judge according to one's understanding of the spiritual, while aiming throughout at supporting the patients and promoting their psychological integrity.

Appendix: three clinical anecdotes: (Personal details have been anonymised to maintain confidentiality).

1) Y is a Jewish woman in her late sixties, whose life was tragically marked by the holocaust. She was not part of it directly but as child she and her mother fled Austria to the safety of the United Kingdom whilst all her relatives left behind were captured by the Nazis and perished in Auschwitz. She says she has never enjoyed any pleasure in her life and, still depressed, continues to contemplate suicide to this day. She is lonely, resentful and leads a reclusive existence during the day. In the evening and at night, when she says she feels more secure, goes out and does her shopping. Many years of psychiatric treatment and psychotherapy have yielded little result, and she is resolute. She does not wish to change, is highly cultured and a walking encyclopaedia on Sigmund Freud. Her lifestyle is eccentric but at the core of her psychopathology is a betraying God and a desperate need to believe in an afterlife. She has rejected formal Judaism whilst still tied by her roots and morality, and unforgiving of God's weakness in allowing the destruction of her family. She seeks the presence of her mother, whom she hated and loved, through spiritualists and attends their services. This gives her more immediate answers, makes her believe in the existence of life after death, and even puts her in touch with her mother. Funnily enough, just as they would argue when her mother was alive, so they still argue today. She is still seeking to reconcile her behaviour with who she is. She is betraying the God who betrayed her and in so doing they seem to have kept quite close to each other, albeit with caveats. Her only answer at this point remains spiritualism and she is not healed by psychotherapy or behavioural interventions, least of all antidepressants. Spiritualism and Judaism have created in her an effective perception of life permanence after death, and in this way affirmed her Jewish morality that prevents her from committing suicide.

2) M is in her eighties and has been suffering from dementia for a number of years but matters got much worse when in recent months she started neglecting herself. Every day for many years she has walked to the local Roman Catholic Church, attended mass and returned to her flat. She used to be much involved in charitable activities and was loved by all her friends for her devotion and generosity. Her illness has changed her, she is psychotic, believes that people are against her, accuses them of wishing to do her harm, does not want anybody to help her, does not sleep and knocks at her neighbour's door at any time of night or day. She wanders out into the street at night and does not know how to return home. Finally, for her sake, she is taken into hospital under a Section of the Mental Health Act. Her arrival on the ward is utterly traumatic, she is restless, aggressive and requires sedation. The staff say that she picks her bag from time to time saying she is "*going to Mass, see you later*", then aimlessly wanders into the circular corridors of the ward, losing her patience, swearing that she will get back home and does not need doctors.

The RC chaplain was called to see her, and also the local priest. The day he visited she recognised him, listened to him and calmed down. The effect on her behaviour and her mood was so dramatic that no sedation was needed that evening. Both priests continued to visit regularly and whenever we could, we made sure she would go to mass accompanied by a nurse. This intervention was effective in managing her behaviour.

3) A patient with dementia at a very advanced stage in her illness, well into her eighties, very frail and very confused. My office is on the dementia ward and looks like a doctor's office; there is a computer, an examination couch, stethoscope in view, untidy desk and mouldy cups of coffee. But Mrs B was not looking for me when she opened the door, smiling at me and then in a whisper asked, 'Is this Roman Catholic or Church of England?' I replied, 'I do not know, my dear, which one would you like?' She did not answer but quietly sat next to me whilst I kept on typing the last report, listening to a pop station on the radio. She sat, tranquil in whichever chapel she thought she'd found, then stood up and tiptoed her way out of the door, which she carefully closed behind her. Well, I thought, she had made her point. Perhaps for a brief moment and despite her confusion her 'God', whatever 'God', has just given her back a glimpse of her dignity.

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