Footpaths: Spirituality, Psychiatry and The Work of Care

Introduction

I was drawn to psychiatry as a career because I felt that this was *the* field where *medicine, meaning of life and spirituality* were intertwined. Within the same consultation, I might adjust a medication dose and also listen for what a life means to the person before me. That possibility felt true to what I saw in training subsequently: bodies and biographies move hand in hand, and treatment often works best when both are taken in view. I found that the clinic could be an ordinary room where physiology and story coexist without one negating the other, and that felt like the right room for me.

Spirituality as Meaning in Clinical Life

The meaning of life, for many people, is made from their work, love, craft, beauty, and the small fidelities of daily life. In this sense, spirituality can be understood not as a set of beliefs to be endorsed, but as the way a person locates themselves in relation to what they take to matter most—what gives coherence to suffering, direction to effort, and grounds for hope. *Religion*, for some, is *one* well of meaning among others; for others, it is *the* well, calling towards a transcendent ideal meaning of life. The latter has been true in my own case, and it is this awareness that has drawn me towards the interface between *religion, spirituality, and mental health*. I have tried to be conscious of this in my career so far and have found this awareness quite rewarding, giving rise to useful reflections. In practice, I try to hold a distinction so that I neither assume faith where there is none nor ignore it where it quietly carries someone through their week. Some patients speak in a spiritual grammar, some do not, and either way our task is to understand what helps them endure and change. When colleagues say that psychiatry treats the person as a whole, which in fact is *the most common reason why most choose psychiatry* [1], I hear an invitation to be curious about biology and biography, a network of synapses as well as narratives, and, more often than

not, the spiritual or religious sources that shape how suffering is named and how hope is kept [2] [3]. I have also come to take spirituality as a functional component of the human experience rather than a theological problem to be solved.

In clinical work, that openness needs a structure that keeps us grounded. I am grateful for the scaffolding: the biopsychosocial frame that widened medicine's imagination, and the biopsychosocial–spiritual proposal that may, in some cases, make our formulations more inclusive and complete [2] [3]. A formulation that includes spiritual concerns when they clearly matter to our patient does not sanctify our work; it simply admits another piece of reality. [4]

A Shared History of Suspicion

Across the last century, some psychiatric figures treated religion as a vestige of childhood or a culture-bound defense, and some religious voices treated psychiatry as a rival authority that threatened conscience, community, or revelation [5] [6]. I suspect both impulses were understandable in their context, while psychiatry was claiming scientific ground; faith communities were protecting moral worlds, but this also produced avoidable harms: delayed help-seeking, shame where compassion might have helped, and clinical blind spots where *meaning* could have been explored. There is an argument for a more balanced approach. Psychiatry can attend to causes, functions, risk, and change without adjudicating theology; religious and secular worldviews can offer purpose, belonging, and practices without replacing treatment.

Footpaths: How Spirituality Helps, Hinders, or Complicates Care

I have come to think that the relationship between psychiatry and spirituality is less a fixed bridge and more a set of cautious *footpaths*. For some people, religious life seems to offer structure, belonging, and a grammar for hardship; for others, it may become another arena where fear or shame gathers. I have found it helpful to think of these footpaths as taking a

few recognisable forms. Some are steadying, offering rhythm or meaning that supports recovery. Some are narrowing, quietly reinforcing fear, guilt, or avoidance. Others are ambiguous, helpful in one season and constraining in another. Still others are collaborative, where spiritual care and psychiatric work walk alongside one another with clear roles and consent. Thinking in this way helps me stay curious without being naive, and attentive without assuming that every path leads somewhere safe. Without this lens, psychiatry risks overlooking both opportunities for recovery and sources of harm embedded in how belief is lived.

Stabilising footpaths are those where belief or practice seems to support ordinary therapeutic goals. For some patients, familiar prayers, rituals, or protected times of rest appear to reinforce sleep, routine, or emotional regulation. The value here is not theological correctness but functional steadiness: practices that help someone return, again and again, to the work of living and recovering.

Obstructive footpaths are those where spiritual language or practice amplifies distress rather than relieving it. Shame-saturated beliefs, punitive images of the divine, or rigid moral interpretations can deepen anxiety, depression, or compulsive cycles. In these cases, the clinical task is not to challenge belief itself, but to notice when a path that once offered meaning has become narrowed by fear.

Ambiguous footpaths are the most common and the most clinically demanding. In my clinical practice in psychiatry in Pakistan, I have noticed that relaxation exercises framed within a familiar prayer or verse are more acceptable, and therefore more consistently practised, than a purely secular script. The content matters less than the felt safety that came with words already known by heart. But the same ritual or belief, steadying one person, may quietly function as avoidance or safety behaviour for another. Here, careful

attention to intention and effect matters and helps: are we practising courage, or fleeing discomfort?

Collaborative footpaths emerge when patients explicitly wish their spiritual tradition to be involved in care. When roles are clear and consent is explicit, collaboration with chaplaincy or faith leaders can support engagement and dignity without blurring clinical responsibility. These paths tend to be safest when they are walked side by side rather than merged into a single authority.

The evidence echoes that certain forms of religious involvement may relate to lower rates of depression or substance misuse and to greater purpose and life satisfaction, while religious strain, guilt-saturated or punitive beliefs, can relate to worse outcomes [7] [8]. Those are small-to-moderate effects, and they appear to depend on who the person is, what exactly they practice or believe, and what outcome we are measuring. I read these findings as reasons to ask better questions. I am mindful that publication bias may inflate positive findings, that measures are not always cross-culturally equivalent, and that observed links are often mediated by social support, health behaviours, and peace rather than faith per se. But when a result is modest and heterogeneous, it may also be telling us to look *more closely* rather than to stop looking. For psychiatrists, the significance of these findings is not causal certainty, but the reminder that belief systems often act as amplifiers of existing vulnerability or resilience.

The measurement literature can help us understand why generalisations tend to fray. It suggests that “religion” is not a single variable but a bundle of behaviours, beliefs, communities, and struggles. Organisational practice such as attendance may track social support; private devotion may track coping style; intrinsic orientation may track motivation; strain may track conflict or loss of trust [9] [10] [11]. If we ask simply “Are you religious?” we probably miss the very features that matter for care. If we ask with a little more texture, we

may hear how to align treatment with what already helps. What I argue for is not the inclusion of spirituality as an ‘add-on’, but a way of thinking about meaning as clinically active, sometimes protective.

Belief, Psychopathology, and the Clinic Room

That attention to details has helped me when I have listened for scrupulosity and obsessive–compulsive disorder (OCD), which I have found most interesting. On paper, we all know that *scrupulosity* can look like *piety* and that piety can shelter compulsions; in real life, the edges are much softer. A person who grew up hearing that a *thought* is morally equivalent to an *act* may experience an intrusive image as a kind of deed, and find themselves predisposed to experiencing thought-action fusion. A passing blasphemous word, a sexual image, a moment of doubt, what might be mental noise for one person can feel like a stain to another. I have watched, and have also recognised in myself, how a belief invites an obsessive loop: a thought arrives, it is judged as sin, the judgment spikes shame and anxiety, and a compulsion, prayer repeated to perfection, washing, checking, confession, momentarily neutralises the fear. Relief then reinforces the ritual, and the loop tightens. My experience is that gentle psychoeducation about thoughts, that thoughts are not actions; that responsibility can be placed on behaviour rather than mental noise, as well as clarifying religious misconceptions, can open the door for freedom for some. This is also very beneficial to pave the path for subsequent behavioural work in exposure and response prevention. When a person’s own tradition permits it, I have wondered whether reframing prayer as a chosen practice rather than an emergency washing of the mind reduces the compulsive grip. I have seen it take patience and collaboration with family or faith leaders who understand the difference between conscience and compulsion [10]. In every instance, I try to keep my language tentative enough to leave room for the person’s agency and belief.

I knew a patient who was tortured by religious obsessions in the context of his OCD. While medication and CBT had their role, the parallel involvement of local religious leaders was

undoubtedly beneficial in terms of imparting appropriate reassurance and getting him motivated enough to engage in therapy. Scientific papers have not only explored this possibility of incorporating religious texts and spiritual practices in the therapeutic process for OCD, but have also highlighted the importance of collaboration with faith leaders for early detection and timely initiation of treatment for this debilitating condition. [12] [13]

Because themes like this surface regularly in practice, I have come to think that psychiatrists benefit from learning a little of the languages people bring into the room. I do not mean only religious language, but the words they already use for courage, rest, responsibility, or forgiveness. Sometimes those words are explicitly spiritual; sometimes they are secular and practical. What matters clinically is that these words are not interchangeable. Misunderstanding what a ritual signifies, or what a phrase implies, can quietly derail alliance, while recognising its meaning can help us align treatment with how a person already makes sense of effort, failure, and repair.

The introduction of “Religious or Spiritual Problem” as a nonpathologising category in DSM-IV felt like a positive step, less like a theological gesture and more like a clinical tool, one that lets us document crises of faith or grief at losing faith without squeezing them into ill-fitting diagnoses [14] [15]. Naming the problem in that way may lower defensiveness and invite more honest conversation. It also seems to remind me, as a clinician, that I am treating distress and impairment, not adjudicating doctrine. That boundary, clear, kind, and practical, often calms the room.

Over time I have settled into a loose, working map for asking about these matters. First, I try to understand whether anything religious or spiritual is active for this person at all; many people simply do not find those words helpful. If something is active, I ask, often in plain, tentative language, what helps and what hurts. “When things become difficult, what, if anything, helps you carry it?” “Are there practices that steady your breathing or attention?”

“Are there beliefs that make this harder?” The questions are ordinary; the answers rarely are. Sometimes a person discovers, in answering, what they did not know they knew. Once, when I asked this question, the patient looked at the floor for a long time and said nothing. I remember thinking I had crossed a line. Later, they told me it was the *first time* anyone had asked.

The distinction between “faith” and “meaning/peace” has been especially useful. Measures like the FACIT-Sp suggest that a sense of meaning and peace may relate to well-being even when formal religious identification does not [16]. This finding fits clinical life: people may not wish to talk about God, but they may very much want to talk about purpose, dignity, or belonging. The WHOQOL group’s inclusion of spirituality/religion/personal beliefs in quality-of-life work seems to recognise that, for many, life is appraised through those lenses whether or not they sit in a pew [17].

When a patient does want support that crosses into the religious or spiritual, collaboration with trained chaplains can be useful. Tools like FICA or RCOPE-informed questions offer a scaffold without prescribing content, and chaplains who work closely with clinical teams often share a careful, non-coercive style [11] [18]. A practical and simple way of doing so is staying informed of the local pathways to consented referral to NHS Spiritual Care/Chaplaincy in our trusts.

There are places where spirituality seems to meet specific clinical work quite naturally, though not without risk. I have found myself wondering whether daily prayers support stability by protecting sleep and routine. The point is not that ritual replaces medication or psychoeducation, but that familiar structures, in the form of the stabilising footpaths, may reinforce habits we are already trying to build [3]. For some families, a protected day of rest, such as Sabbath, appears to make boundaries around evening stimulation or bedtime easier to hold, and occasionally that small foothold generalises. At the same time, I have learned to

be cautious: certain practices can harden into obligation or self-criticism, particularly in anxious or perfectionistic patients. The clinical task, then, is not to promote ritual, but to notice when that *footpath* is *stabilising* and when it is *ambiguous*, and to respond accordingly. These reflections are grounded not only in clinical pattern-recognition but also in a literature that suggests why these practices do hold for some people some of the time [19] [20].

Trauma work often raises questions about guilt, injury to conscience, or the need for witness. We have met people for whom language of lament or forgiveness makes space to tell the truth about harm and responsibility. When that language belongs to the patient, it may run alongside therapy without friction. For others, explicitly religious language does not fit; different metaphors, repair, accountability, courage, may serve just as well. The literature also nudges us to look for strain, not only solace. Spiritual struggle, feeling abandoned, punished, or confused, can predict distress and seems to deserve attention in its own right [11]. A brief question, “Are there any beliefs that make this harder?”, can open conversations to move care forward in ways we’d not had anticipated.

Having initially worked in psychiatry in certain areas of Pakistan with limited mental health awareness, I have often come across shame about symptoms and been involved in discussions with the family that “weak faith” is not a diagnosis. When someone would tell me that they have been praying harder to cure their depression or stop a panic attack, I might wonder aloud whether learning to ride the wave of these problems could sit alongside prayer rather than compete with it.

Boundaries, Consent, and the Ethics of Engagement

Boundary questions are the hardest and, perhaps, the most important. While most would agree that we should always try to avoid using clinical authority to promote our own worldview, it is equally important not to ignore resources a patient clearly values because we

are ‘uneasy’. Consent helps here. If a patient says they would like their tradition involved, there is an argument to involve it with clear roles. Cultural formulation habits, asking for the patient’s explanatory model, naming differences kindly, protecting safety, seem to carry most of the load [15]. While these routines may look simple on paper; in a busy clinic they can feel like a steady handrail.

There is, of course, a principled concern that psychiatry should remain firmly secular in its clinical stance, engaging spirituality only through referral rather than direct exploration. From this view, any substantive engagement risks boundary violations, role confusion, or the misuse of clinical authority, particularly given the power asymmetry inherent in psychiatric work [21]. Given the history of coercion, both religious and medical, this caution is not only understandable but ethically necessary. What I have found missing from much of the literature, however, is an account of the quiet ethical discomfort that can accompany the clinicians’ choice of deciding *not* to engage spiritually.

I have found it difficult to articulate the ethical discomfort that can arise at the opposite pole: the quiet sense that, in avoiding spiritual material altogether, we may also be using our authority to privilege a particular worldview. Avoidance and silence, *too*, can shape the room. When something clearly matters to a patient and is left unspoken because it makes us uneasy, the risk is not neutrality but omission. The ethical task, as I experience it, is not to resolve this tension, but to remain alert to it, and to notice when engagement would intrude, and when avoidance might inadvertently neglect. Consent, role clarity, and a focus on function rather than belief can become our practical safeguards when walking this line.

I am also grateful for a simple, durable insight from Frankl, a psychiatrist who survived Auschwitz: meaning may not remove pain, but it can change the posture with which a person faces it [22]. That stance, a little more agency, a more forgiving story, a renewed link to others, may in turn make adherence and skill practice more likely. That is not metaphysics; it

is clinical pragmatism shaped by how people actually live. In that sense, the meaning of life, religious or otherwise, sometimes ends up being one of the levers we can help people find.

Conclusion: Small Habits, Ordinary Rooms

If there is a single change we need to keep returning to, it is this: To try to ask, gently and without agenda, what gives someone strength when things are hard. Sometimes the answer is a friend or a football pitch. Sometimes it is a psalm. Sometimes it is “nothing,” and then we can be honest about how hard that is and we can keep going. These answers rarely dictate a plan, but they often illuminate one. They can show where to build, what to avoid, and who else should be invited into the work.

I suspect that the future of the conversation surrounding spirituality and psychiatry will depend less on manifestos and more on small, dependable habits: measuring what can be measured; asking what matters to the person; keeping boundaries clear; and being willing, when invited, to work alongside the traditions that already carry people through the week. Some studies suggest that such attention may improve engagement and satisfaction with care; it can also improve trust, which as we know is often the beginning of all good things in psychiatry [7] [17]. For future research, it may be that more cross-cultural validation, more attention to non-theistic forms of meaning, and more longitudinal work on mechanisms could sharpen what is now a helpful but broad picture [9] [17]. In the meantime, clinic rooms remain diverse even when studies are not, and a little curiosity may go further than any single paper.

Having worked in psychiatry, I no longer feel it is completely accurate to say that psychiatry is where *medicine meets religion.* I do think, though, that it is where *medicine meets people*, and people bring meanings, some religious, some spiritual, some secular, almost all complicated. Our work may be to notice them and provide gentle support while

acknowledging them. If a tradition provides courage for therapeutic work, we can certainly welcome it.

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