The Integration Of Spirituality In Psychiatric Teaching:
The Lesson To Be Learned From Our Patients

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Abstract

Emerging from historical separation, science and spirituality are reaching out in the struggle for convergence. This is in tune with holistic approaches to assessment and management, and in this the training and teaching of psychiatry holds pre-eminence. There is a striking link between many aspects of psychopathology and coping mechanisms and the underlying moral and cultural values modifying behavioural expressions and outcomes. The world scientific literature is also swelling with contributions producing such an evidence base.

The established methods in the teaching of phenomenology, psychopathology and case management do not produce effective criteria for a meaningful and practical assessment of morality, culture and sense of the spiritual. Integrated approaches are established in many schools in the USA, and in the UK interest continues to grow, from the first notable pioneers to the establishment of a Spirituality and Psychiatry Special Interest Group at the Royal College of Psychiatry, and more recently institutions such as St. George's Hospital Medical School in London. Here consideration is being given to introducing the training of awareness of spiritual matters in the assessment of patients from multi-ethnic backgrounds in the undergraduate curriculum.

Whilst diagnostic categories and standard methods remain useful practical tools, the challenge for the future psychiatrist is twofold. First, it will involve training in attitudinal changes and concentrating on the qualitative encounter and its meanings, more effectively engaging in therapeutic relationships by suspending judgement and allowing patients to 'teach' about their existential constructs, faiths and doubts. Finally, it will involve training in appraising the core moral perspectives at play in diverse communities. Psychiatric thinking may produce theories resonating in societies divided in the name of different moralities, and it is also incumbent on such powerful individuals - psychiatrists - to mend missing links and strive towards a more integrated discipline rooted in tolerance of human and moral diversities.

Introduction

Evidence on the importance of spiritual matters in the care of people with mental illness continues to gather, and with it the necessity to adapt the education and training of future generations of professionals. The USA has by and large pioneered the introduction of the teaching of spirituality in the curriculum of many medical schools, to date including about ninety centres [1]. In the United Kingdom, the major impetus towards establishing teaching of spirituality in psychiatry must be attributed to the work of the Special Interest Group (SIG) at the Royal College of Psychiatrists. Currently, a sub-group of the SIG continues to work on identifying teaching institutions willing to pioneer educational projects, whilst the Royal College of Psychiatrists is considering the proposal for introduction of a specific section on spirituality in the syllabus for the MRCPsych exams.

One important project is being developed in St George's Hospital Medical School, London. Here a local interest group, composed of three local psychiatric teachers, one theologian, one student representative and a member of the specialist interest group from the Royal College of Psychiatrists, has for the past twelve months looked at how to best integrate the awareness and learning of spiritual matters in the

curriculum of undergraduate medical students. Rather that distinct courses, spirituality is being introduced in a number of areas, complementing the teaching already taking place, and shorter special study modules are planned for those students who will manifest a keener interest in the subject.

From old to new process

If awareness of spiritual matters – not necessarily religious – is to be introduced in the teaching of psychiatry, one cannot help feeling that some aspects of it may need to undergo a radical change. At the point of assessment, the holistic approach becomes central, as does a fuller interpretation of the interaction with the patient.   This is a potential paradigm shift, in which the established method of teaching and training new psychiatrists is challenged. A paradigm is what gives security to an establishment and conserves its basic integrity in the face of change. It may allow for historical variations in content but it is unlikely to sustain breaches in form and method. If this happens, the paradigm changes, and there will be resistance. Not all may wish it to change.   But does the paradigm belong to the psychiatrist or to the patient whose care is at stake?

How do statistical analysis and generalisation relate to the actual individual in mental distress? What does ticking a series of boxes in a checklist tell me about the individual? Also, in clinical practice, not one single individual will display exactly all the symptoms listed in the Oxford Textbook of Psychiatry for his/her particular condition at the point of assessment. There is always 'something missing' in the reference book. Yet the text contains the necessary knowledge base, updated standard diagnostics and guidelines in care management. It can therefore be argued that what is missing is not in the book, but that it is likely to rest within the very person of the patient, who can give the clinician more information about himself through unique feedback than any reference book. Could it just be possible then, that in the complete absorption to learn one's subject matter to pass the MRCPsych, one eventually ends up isolating the individual from the disease?

Classical psychiatric training remains largely medical and scientific, based on reference to standardised texts and phraseology necessary for shared multi-professional understanding. Adding a few theoretical concepts on religiosity and world practices would surely not suffice. One's fundamental personality and life constructs are put to the test by stress and disease, and through stress and disease the individual patient speaks [2]. The worse the psychological pain of the patient, the more he/she will tell you about those things that hold the highest meanings in their life. It will come through every single expression of his/her emotions and behaviour, and even through their delusions. This calls for a professional attitudinal shift in the clinical encounter and for the clinical encounter to come to life at a deeper level.

The psychiatrist and the patient

The psychiatrist is a human being, innately predisposed - as are all human beings - to becoming aware of mental and psychological processes within oneself, and hence to self-reflection. He/she is also a member of a professional body held together by standardised knowledge. As an individual and as a professional, he/she is in turn the product of society, history and politics. Through training he/she acquires scientific knowledge and espouses theories passed on by their teachers and generations of teachers before them. He/she learns a professional modus operandi, which is phenomenological, and uses universal methods of diagnosis and ratified curative methods [3].

The assessment of the patient rests on an evidence-base, the observation of symptoms, diagnostic standards and a labelling process. Yet, what constitutes evidence when generalisation seems to have driven it away from the individual encounter? [4] The psychiatric approach emerges as detached, neutral, and eventually assessing an individual patient becomes an automatic and non-reflective process.

This method serves an internal function of self-preservation and avoidance of exposure to emotional processes – even pathological – that the psychiatrist may harbour, and satisfies the requirement of keeping a safe distance between patient and clinician. Professionalism can therefore come across as uncaring, but it can even be effectively neglectful if in the process of assessing someone's psychopathology the psychiatrist ignores important elements that feed into and maintain the essential personhood of each individual.

This phenomenon finds its reflection in the wider sphere, where the acquisition of knowledge through research may be inspired by systems rather than persons. The more the focus is skewed away from the individual, the more psychiatry shows itself vulnerable to becoming an uncritical instrument of political trends. The influence of these may not be positive, and may confuse or even pervert priorities.

As for the patients, they also bring three major dimensions to the encounter with the psychiatrist: individuality, affiliation to local milieu and the embodiment of national and international life style and political ideologies. They are people with unique identities and life constructs, formed by life events, with a body and mind, moving and breathing and sharing in both a narrow and wider context. Biological, psychological and social dysfunction inevitably threaten the person's spiritual balance and arouse a primary search process in which the individual is likely to feel fundamentally alone. They are also individuals in psychological pain, who understand their mental illness in a unique way and who need to find validation to the meaning of their experience and ways of coping with it.

Mental health and spirituality

An attempt at conceptual integration is therefore necessary to generate an attitude that will facilitate effective understanding. By examining points of convergence, a vision may emerge to a way of discovering what may be missing dimensions in the assessment of mental illness.

The definition of mental health includes absence of emotional pain, self-actualisation, confidence and satisfactory interaction with other individuals and within society.[5] At the core of spirituality - not necessarily religion - rests the quest for the meaning of life, self-reflection, the awareness of the finite nature of sensory perception, the establishment of relationships, the need to be listened to and the need for intimacy and comfort, and making sense of life stages and mortality.[6]

Examples of possible integration of psychological and spiritual exploration are in the study of personality, morality and emotions. Systematic studies of personality connect cognitive orientation towards spirituality with extraversion, but forms of spiritual religiosity have also been linked to psychoticism and schizotypal personality traits. [7, 8, 9] Religiousness is specific to each individual and establishes itself as a stable belief system [10, 11, 12] and there have been suggestions of correlation between childhood traumas and the development of spirituality .[13]

The link with morality is through the value of virtues such as love, gratitude, humility, self control and wisdom, that are nurtured through social learning and imitation and become stable traits said to provide psychological strength and well being. [6, 14, 15]

Finally, spirituality and emotions are intrinsically connected [16] and may for example relate to the degree of likely successful control over feelings of anger and depression. Demoralisation and loss of hope [17] are at the core of depression, and here the patient's spiritual attitude may reveal differing patterns of dealing with combinations of acute and chronic stressors. The splitting and disconnection of schizophrenia carry fear and isolation, and psychopathology may betray spiritual constructs that could serve either constructive or destructive ends at the time of illness.

Psychopathology, spirituality and diversity.

Man's predisposition towards transpersonal experience is universal, instinctive and pre-verbal, and in turn acts as foundation for, and evolves into, language, forming part of the identity of the social individual. Societies are historical and permanent cradles of spiritualities that have assembled under shared notions for their transcendent languages, forming different religions. The size of world religions are witness to the magnitude of this phenomenon, one that underpins the way in which nations deal with the fundamental question of human origins and existence, morality, type of social interaction, disease and mortality. Whilst awareness of transcendence may well be innate, formal aspects of spirituality are first acquired through families and social network, verbal and written traditions and rituals. The experience of religion is traditionally handed down from generation to generation.

There is therefore a necessity to extend understanding to different races, countries, moralities and religions, and to grasp constructive and destructive psychosocial and socio-pathological issues of formal spiritualities. Spirituality may connect and also disconnect a diverse world. Here, if understanding, acceptance and tolerance of diversity do not happen, whole groups become intransigent, dysfunctional, locked in self-destructive spirals and racial retaliation. [18] At a sociological level therefore, the dialogue between mental health science and spirituality becomes relevant to the unravelling of different presentations of mental illness across different traditions, and to the appreciation of where the group the patient belongs to is at in terms of morality, beliefs, range of emotional expression and behavioural patterns, conflict and conflict resolution. [17, 19, 20]

The lesson to be learned

Categories of spiritual exploration pertain to the personhood and hence lie in the background of all categories of mental disorders, making the successful assimilation of spirituality in the teaching and training of future psychiatrists a pervasive requirement. Knowledge of sociological and intercultural issues must be extended, and there must be a concurrent development of personal skills sufficient to enact a more holistic process in one's practice.

Each patient has always spoken and will continue to speak the language of his feelings, experience, upbringing, fundamental beliefs or lack of, and to reflect attitudes of his culture. The exercise for the clinician is in attempting to reach the patient at a level where enough space is given to the interaction with the person and not only the clinical case. [6]

A paradigm shift may dislodge established attitudes; deprive clinicians of securities previously assured by empirical methodologies and lead to a sharper awareness of the process of interaction with someone in mental pain. The patient does not want the psychiatrist to be at a higher level, and looks for a type of resonance that will enable him to feel free to use his own language, to tell who he is and where the pain is coming from, and - more importantly - what the pain means to him. In a live and dynamic 'conversation' with the patient, one no longer has to be feared and revered as someone who is about to pass judgement on someone else's mental failings. If judgement is even briefly suspended, the patient may seek validation, and use active resources that improve communication, compliance and outcome.

Ultimately, the lesson to be learned from our patients is that each one of them – a human being in his entire dignity - is the teacher at the point we meet him. He carries the heritage of social history, values acquired through family and social groups, and the meanings of his own unique life experiences. And the teacher is in pain. He will use his own language to express this pain, one that the professional can decode more effectively with a change in attitude, practice and a wider knowledge base. In this way teachers of psychiatry may develop - and train others to develop - sufficient skills to focus on the eloquent and diverse human being that will each time emerge to fill the elusive gap that no book can cover.

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