

The Faith of the Psychiatrist

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It has often been observed that there is a 'religiosity gap' between the psychiatrist and the user of mental health services. Psychiatrists are less likely to be affiliated with a faith community, or to believe in God, than their patients.

Although much of the research illustrating this trend is from the United States, two important studies have been conducted in the United Kingdom. The first of these (Lawrence, Head et al. 2007) studied 316 members of the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists. They found that 58% of their sample reported religious affiliation. They did not include a suitable control group in their study. The second (Neeleman and King 1993) studied 231 consultants and trainees in psychiatry at the Bethlem, Maudsley and Royal Free Hospitals. They found that only 27% reported a religious affiliation, and only 23% reported a belief in God. Although they did not have a control group, they noted (on the basis of other published surveys) that up to 80% of the general population believe in God. They also suggested that the difference from the general population in terms of religious affiliation was much less.

This area of research has been marked by lack of suitable comparison or control groups, to the extent that it is difficult to say with confidence that evidence for a 'religiosity gap' actually exists. Most usually, comparisons are made with general population surveys, which assume that mental health service users are representative of the general population. In fact, there is reason to believe that religious affiliation protects against mental health and that mental health service users may therefore be less likely to be so affiliated than other members of the population (Koenig 2005). However, one study from the US showed that psychiatrists were less likely to be religiously affiliated or to believe in God than other physicians (Curlin, Lawrence et al. 2007). Another demonstrated lower rates of religious affiliation among psychiatrists than social workers or family therapists, but only very slightly lower rates than clinical psychologists (Bergin and Jensen 1990). Perhaps the best study to date, conducted in Canada (Baetz, Griffin et al. 2004), did include a comparison group of mental health service users and found that 51% of psychiatrists, but 71% of patients, reported belief in God. However, psychiatrists and patients were not different in terms of self-perception as either 'spiritual' or 'religious'.

If psychiatrists are less likely to believe in God, or to be religiously affiliated, they appear nonetheless eager to engage in debate on the place of spirituality and faith in clinical practice. An editorial by Harold Koenig in *Psychiatric*

Bulletin last year (Koenig 2008) suggested that good psychiatric practice should include:

- Taking a spiritual history
- Supporting healthy religious beliefs
- Challenging unhealthy beliefs
- Praying with patients (in 'highly selected cases')
- Consultation with, referral to, or joint therapy with trained clergy

None of these proposals were completely new, and the key points had been made previously by distinguished speakers at meetings of this College (HRH The Prince of Wales 1991; Cox 1994; Sims 1994). Regardless of this, Koenig's editorial provoked a heated controversy, in which correspondents described themselves as 'alarmed' at his recommendations (Lepping 2008; Poole, Higgs et al. 2008). The proposal to consider praying with patients in 'highly selected cases', about which Koenig himself had urged caution, was described as 'troubling' (Carter 2008), 'dangerous ground' (Mansour 2008) and 'highly controversial' (Mushtaq and Hafeez 2008). Why, then, was there such a heated response?

Partly, I think, the answer may be found in transatlantic cultural differences. The United States is a very religious nation, and the United Kingdom is more secular. The acceptability and language of public religious discourse are very different in our two nations. Secondly, I wonder if there is a misunderstanding about the nature of religion and spirituality. It is patently obvious that not all people (psychiatrists or patients) are religious. It is not at all obvious that there are any people (including psychiatrists or patients) who are not spiritual. Many would argue that this is a universal dimension of human experience (Sims and Cook 2009). Thirdly, it is difficult to avoid the possible conclusion that such emotive responses might be indicative of an approach to engagement with patients which is found to be threatening or personally challenging in some way. At the very least, it would appear that for some, discussing religion or spirituality engages doctor and patient in a level of discourse which is seen as transgressing professional boundaries (Poole, Higgs et al. 2008). But fourthly, and finally, there seems to be the strong implication that discussing such matters with patients might be actually harmful. Whilst abuses of spirituality or religion undoubtedly may be harmful, it is not at all clear what the evidence is for suggesting that these subjects should be excluded from discussion with patients.

In 1965, in his classic work *The Faith of the Counselors*, Paul Halmos suggested that counselling (within which he explicitly included psychiatry) was itself a kind of 'faith' (Halmos 1979). In particular, he saw it as going beyond that which is purely research based and entering into a domain within which

(quite properly) people are treated as having value and being worthy of respect and even love. Similarly, HRH the Prince of Wales, in his address to the College in 1991, reminded us that:

Care for people who are ill, restoring them to health when that is possible, and comforting them always, even when it is not, are spiritual tasks (HRH The Prince of Wales 1991)

The then Archbishop of Canterbury, George Carey, in his address to the College in 1996 (Carey 1997) suggested that there is a common inheritance of religion and psychiatry. In particular:

- They both understand health as something 'beyond the physical'
- They share values of faith, hope and love
- Psychiatry and religion need each other
- Society needs psychiatry and religion to work together

Perhaps, then, we should think of the 'faith of the psychiatrist' in at least two different ways. On the one hand, it refers to his or her sense of belonging to a faith community, or the holding of religious beliefs. On the other hand, it reminds us that psychiatry itself possesses some of the characteristics of faith traditions, characteristics that overlap significantly with those of the religious traditions themselves. This should not be a cause for concern, but rather for celebration. It reminds us that human beings are of greater value than can be demonstrated by the scientific method.

Does the faith of the psychiatrist make any difference to clinical practice? In a study of evangelical Christian psychiatrists in the United States, respondents reported the Bible and prayer to be more effective than psychotropic medication or insight-based psychotherapy in the treatment of grief reactions, sociopathy and alcoholism (Galanter, Larson et al. 1991). It would therefore appear that faith does, at least in some circumstances, affect psychiatrists' perceptions of what is most likely to help their patients. However, perhaps more importantly, mental health service professionals report that it is important to them to know the religious or spiritual orientation of their patients, and that spirituality or religious orientation affects their choice of psychiatrist (Baetz, Griffin et al. 2004).

While there is, without doubt, the possibility of spiritual or religious abuse in clinical practice, the American Psychiatric Association long ago drew up *Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitments and Psychiatric Practice* (Committee on Religion and Psychiatry 1990). Fundamentally, these guidelines require that psychiatrists show respect for the religious beliefs of their patients, and that they should not impose their

own religious (or anti-religious) beliefs or ideologies upon their patients. Within the guidelines, assessment of patient spirituality and religious belief are accepted as fundamental. We may well ask why we do not yet have such guidelines in the UK.

The Spirituality and Psychiatry Special Interest Group (SIG) of the Royal College of Psychiatrists has taken an interest in the development of the new College curriculum and the place (or lack of a place) of spirituality and religion within it. In the process of its work on this subject, the SIG working group proposed that the following might be included amongst basic spiritual competencies of the psychiatrist:

- Explore how your own spiritual/religious beliefs may/may not coincide with those of your patient.
- Identify when spiritual/religious beliefs facilitate or obstruct the doctor-patient relationship.
- To become able to engage and be comfortable with the deepest level of personal experience which embodies human spirituality.
- Discerning when spiritual concerns are best dealt with within the doctor-patient relationship and recognising when additional pastoral care is required.

The faith of the psychiatrist is as much a reality affecting the clinical consultation as is any other personal attribute: gender, sexuality, race, social class, culture, personality or political belief. We can try to be completely objective and professional and to ensure that these attributes do not affect our clinical practice. However, the reality is that sometimes they do. Being aware of this, and knowing how to address it, is arguably the best way to demonstrate professionalism and sensitivity to the concerns of our patients.

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