Teaching Residents about Religion and Spirituality

Mary K. McCarthy, MD, and John R. Peteet, MD

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As our nation has grown and continued to accept immigrants from around the world, multiculturalism has become the norm, and the growth of different religions or different subunits of certain religions (e.g., Islam and Hispanic Pentecostalism) is part of this trend. The mass media describe the general public's rising interest in matters spiritual and religious, and point to the incredible range of religious expression in the United States—from Jainism in Michigan to a motorcycle "Christ Club" in New Jersey.[1,2] Religious and spiritual concerns imbue the current political climate: the recent drive for "faith-based initiatives" by President George W. Bush has brought the debate about the separation of church and state back to the fore, and the events of September 11, 2001, have directed attention anew to how religious beliefs can be distorted to justify extreme violence.

Historically, psychiatry has itself also struggled with the role of religion and spirituality in a person's life—from Freud's dismissal of religion as "mass delusion"[3] to the view now generally held that religious beliefs and practices are deeply connected to the patient's developmental history and therefore should be part of the psychiatric interview.[4–6] Clinicians have described the importance of including religion in the assessment of patients facing serious medical illness or death.[7] Others have explored the role of spirituality and religious issues in psychotherapy[8,9] and in the assessment of suicide risk.[10]

Reprint requests: Mary K. McCarthy, MD, Department of Psychiatry, Brigham & Women's Hospital, 75 Francis St., Boston, MA 02115.

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For years it has been thought that psychiatric training, clinical work, and research have occurred in the context of a "religiosity gap" between mental health professionals and patients.[11] This situation may be changing. Although a 1975 American Psychiatric Association poll found that only 43% of psychiatrists believed in God,[12] a more recent, 1992 survey of psychiatry residents' religious views found that over 75% reported a belief in God and that close to 70% reported that religion was important in their lives.[13] One study found that 80% of psychiatry patients consider themselves spiritual or religious, with 48% saying they were deeply religious.[14] Moreover, psychiatric patients often bring distressing experiences regarding religion and spirituality into treatment—such as the questioning of their faith, or conflicts over moral issues (e.g., abortion, birth control)[15]—and psychiatrists are paying increased attention to these issues.

PSYCHIATRIC EDUCATION DEALING WITH RELIGIOUS ISSUES

In the past, psychiatric educators looking at residency training concerning the religious and spiritual lives of patients have found a dearth of didactics in this area. A 1990 survey of American Association of Directors of Psychiatry Residency Training members (80% response rate) revealed that didactic instruction in this area was infrequent and that individual supervision about this topic was highly variable.[16] Discussions of religious problems (e.g., the loss of faith or the conversion to a new faith) and spiritual problems (e.g., a near-death experience or a shamanistic initiatory crisis) were rarely in the didactic curriculum. In response to this curricular deficit, the Accreditation Council for Graduate Medical Education's Special Requirements for Residency Training in Psychiatry (1994) required teaching about (1) the "religious/spiritual" factors "that significantly

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influence physical and psychological development" and (2) "American culture and subcultures," including these cultures' "religion/spirituality."[17] Slowly, psychiatric educators have begun to offer seminars on these topics.

HARVARD LONGWOOD'S EXPERIENCE

In the Harvard Longwood Psychiatry Residency Training Program (Harvard Longwood), training in the issues at the interface between psychiatry, spirituality, and religion began in 1994. That year, one author (JP) was invited to teach one session to PGY-4 residents about dealing with religious and spiritual issues in psychotherapy. The class discussion (in which a resident revealed that he had prayed with a patient) raised enough issues that in subsequent years the course director devoted two, then four, then six sessions to the transference, countertransference, and boundary aspects of working in this area. In 1998, Harvard Longwood was awarded one of the first seven Templeton Foundation grants to develop and support the course "Mental Health, Religion and Culture," codirected by the authors. (Since 1998, 16 more U.S. psychiatry residency training programs have been awarded Templeton grants for innovative curricula in this area.)[18] As a result of receiving this award, we were able to develop a required 12-session PGY-4 course, as well as to introduce important related material (such as taking a religious history) earlier in the residency.

Five years later, the PGY-4 course has a fairly consistent shape. The first session begins with a brief overview of the course objectives, which include the residents gaining (1) an understanding of spirituality and healing in relation to current science, (2) an appreciation of the psychic functions of spiritual/religious beliefs, and (3) the ability to develop treatment approaches to spiritual/religious problems that can be implemented, with sensitivity to countertransference, transference, and ethical implications. During this initial session, residents pair up, take a spiritual/religious history of one another for ten minutes, and then discuss what the experience was like. We find that this exercise immediately helps residents become more comfortable asking questions such as "To what extent has religion played a part in your life?" and "Do you pray or have other religious/spiritual practices?" The residents come to appreciate how asking about this part of a person's life reveals much about the person's family, culture, and worldview. In this session we also describe the format of the course, which includes interactive presentations by invited speakers, group discussion of issues and clinical material, and exposure to relevant literature. We then distribute an annotated bibliography and invite suggestions from the residents for topics for the three sessions that we leave open.

The second session is led by Herbert Benson, MD, a Harvard cardiologist and investigator who heads the Mind-Body Medical Institute. He talks about the physiology and importance of the relaxation response and about its being induced by meditation and prayer across all traditions, and leads the residents through an exercise to elicit the response.[19] Residents are always surprised about how calm they feel after the exercise, and several want to teach it to some of their patients.

In the third session we briefly review the historical relationship between psychiatry and religion, beginning with Freud's rejection of religion as "psychical infantilism."[3] We then consider the several ways that spirituality can function in a person's life—for example, to influence identity, values, moral decision-making, the experience of guilt, and the development of character. Residents reflect as a group on their patients, many of whom illustrate the benefits of 12-step approaches and spiritual care for the dying (or conversely, illustrate religion as a source of distress).

Our invited speaker for the fourth session, psychoanalyst Ana-Maria Rizzuto, MD, asks that a resident present a case to her that has a religious aspect—for example, religiously framed resistance to treatment, such as the failure to trust a therapist from a different religious tradition, or the differentiation between strongly held religious beliefs and delusions. These cases allow Dr. Rizzuto to discuss her research finding that everyone, whether religious or not, has an internal God representation, usually modeled after parental figures.[20] She is invariably astute and incisive, and the residents' only regret is that they find the time too short for a complete discussion.

The next four sessions focus on transference, countertransference, boundary, consent, and ethical aspects of dealing with spirituality/religion in treatment. One of the primary goals of these sessions is to understand the specific transference/countertransference issues brought into treatment when religious and spiritual issues are involved. If the therapist becomes involved with spiritual issues, does the patient see her or him as a moral authority (e.g., leading to a heightened sense of shame), as a religious figure from earlier in the patient's life (e.g., a parochial school teacher), or as a member of the family of faith (e.g., with expectations of shared perspective and closeness)? If the therapist avoids discussion of spiritual issues, she or he may be seen as a distant authority who is uncomfortable sharing information about common values and is therefore overly professional, or as a probably skeptical scientist hostile to belief. Concomitantly, we want the residents to become aware of their countertransference issues toward patients' spiritual concerns. Do they respond to the patient from their own unresolved feelings toward religious figures (e.g., suspicious, admiring, fearful, or resentful) or from unacknowledged attitudes toward spiritual or moral issues (e.g., toward a

patient's religious beliefs that the therapist finds personally repugnant, or toward a patient's spiritualizing style that conflicts with the therapist's interest in promoting psychological insight and independence of thought)? In the boundaries session, we review current guidelines about professional boundaries, paying particular attention to the issue of self-disclosure as it relates to "dual relationships" such as being a patient's therapist and fellow church member, and to the distinction between "boundary crossings" and "boundary violations," the latter of which are harmful crossings or transgressions of a boundary.[21] Dealing directly with spiritual issues in treatment may entail potentially confusing boundary crossings and require more explicit discussion of the therapist's thinking: "If I try to help you explore further these spiritual concerns (or if tell you my own religious identification, or join you in a prayer, or suggest a church for you to try), I want us to understand first how it would help you get what you need from me as a therapist." In what has proved to be one of the more powerful sessions for the last two years, one of the authors (JP) presents a long-term psychotherapy case of a patient with significant psychopathology, a history of incest, and a strong, if not rigid, religious faith; following the presentation, the patient is interviewed by the residents. This session allows the residents to ask questions of the patient—which expands their interviewing skills in this area—and (later) to ask the psychotherapist difficult questions about boundaries, the use of religious ideation as a defense but also as a source of comfort and strength, and the therapist's countertransference.

Since these clinical cases so often raise questions about whether a therapist is really neutral, and about how to deal with religiously reinforced guilt, for the last few years we have devoted one session to the psychiatrist and the moral life, including the concept of moral functioning. In this session we present two perspectives to help frame an approach to the moral aspects of clinical work. One is an understanding of normal moral functioning, which requires the capacity to perform six basic tasks: (1) develop core moral commitments, (2) make moral decisions, (3) implement moral plans, (4) assess one's own behavior, (5) deal with moral failure, and (6) develop morally admirable character traits or virtues. The second perspective is that psychiatry is a moral discipline in being altruistically committed to patients' best interests, and that a good psychiatrist is concerned with the patient as a whole person, including the patient's moral functioning. A resident this year presented a case that posed a moral dilemma for him:

> A gay male patient who is HIV-positive continued to have unprotected sex and not divulge his HIV-positive status to his partners. The resident asked the patient to explore this decision but met with resistance. In fact, the patient could not understand what was alarming the resident, who was, he thought, being judgmental and should have understood how he felt. The resident came to the conclusion, after discussing the case in supervision, that he could no longer treat the patient.

This case provoked a lively class discussion about our responsibilities to our patients, to ourselves, and to the larger society. What if our own moral values conflict with those of our patients? Are we obligated to put these feelings aside in order to continue to treat the patient, or is it sometimes permissible to terminate treatment, and if so, how does a clinician communicate that decision to the patient? The above case, coupled with the class discussion, illustrates not only the moral arena that clinicians sometimes find themselves in when providing clinical care, but also the importance of having a forum available for discussing these issues honestly and openly.

In the three open sessions, residents have routinely chosen to hear about cults, and have found the presentation by Steven Hassan, M.Ed.—a former member of Sun Myung Moon's Unification Church who became a deprogrammer, consultant, and author—very useful in clarifying both the nature of destructive cults and how to help affected patients and families.[22,23] In the other two sessions, the residents have chosen to learn about the specifics of certain religions, such as Islam, Buddhism, and Pentecostalism, and the practices of spiritual direction, pastoral counseling, and hospital chaplaincy, which are helpful in understanding how the general clinical descriptions of belief and practice apply in specific institutional settings and clinical situations. We have learned, however, that inviting two different clergy to the same hour-long session leaves inadequate time to do justice to either tradition.

In teaching this course, we have found that the topic of religion and spirituality has the potential to create divisions in a resident class (as it does in the world at large) because residents have their own deeply held beliefs, some of which may be polar opposites. Each class is heterogeneous (with some students more religious and some more skeptical), and the classes vary from year to year in how safe they feel talking about such differences as a group. Having two instructors who have different perspectives has been reassuring to those residents who fear a "hidden agenda" of proselytizing. These issues require the instructors to maintain sensitivity to the group process and to make sure that there is adequate time to talk about the issues that surface. In addition, we have had to balance formal presentations against the need to provide residents with sufficient opportunities to reflect on and discuss their own questions and concerns—e.g., "What if a patient asks me what I believe?" Residents appreciate help in structuring an approach to patients with religious, spiritual, and moral struggles, but the most successful sessions are actually those that help residents articulate

what they themselves bring to their encounters with such patients. Over the years, the evaluations of the course have shown that residents, no matter what their initial biases, have become more comfortable with, and more interested in addressing, patient's religious/spiritual concerns.

COURSES OFFERED ELSEWHERE

Harvard Longwood faculty and residents approach the topic of religion and spirituality from many different perspectives, and our course reflects the specific context of being in Boston and at Harvard. Although the course draws heavily on an intellectually and culturally rich group of local teachers, researchers, and clinicians, it might be seen as somewhat conservative when compared to such courses offered in other geographical regions—which are also tailored to the zeitgeist of their institutions, local cultures, and faculty interests. For example, a West Coast program offers sessions on topics that are of more interest there—such as "spiritual emergence syndrome" and "altered states of consciousness in relation to spirituality."[24] Other programs have made use of relationships with pastoral institutes and religious institutions to develop and strengthen their courses. One program requires the residents to make field trips to local religious services of different denominations. Another exposes residents to the particular religions in the region that are associated with its Native American Cree, Navajo, and southwestern Hispanic populations. Around the country, psychiatric educators' responses to the challenge of educating residents to be sensitive and sophisticated interviewers of patients around religious and spiritual topics have been creative and diverse.

CONCLUSION

Over the last decade, psychiatry has taken on the task of educating future psychiatrists to be multiculturally sophisticated, with a specific focus on helping psychiatrists understand, respect, and be curious about how religious and spiritual issues manifest in any given patient's life. Harvard Longwood and other training programs around the country are developing innovative courses to engage residents in a dialogue about the impact of religious and spiritual issues on themselves as professionals and on their treatment of patients.

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