Why spirituality matters in psychiatry

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As a core psychiatric trainee working in South London, I have been astounded by the number of clinical situations in which spiritual and religious issues are a central feature of the presentation. It has become almost the norm for me to see patients both in and out of hours who are presenting with overtly religious or spiritual difficulties.

One of the fascinating things about psychiatry is that it draws on a number of different disciplines in the care and treatment of mental disorder. I have always enjoyed the ways in which psychology, sociology, politics, history, the arts, literature and philosophy - to name a few - in addition to neurobiology and other medical specialities, inform psychiatric practice. One of the privileges of practising psychiatry is that a more varied and richer understanding of human nature is positively encouraged.

I therefore find it strange that perspectives from spiritual and religious disciplines are often neglected and are not considered as valuable in understanding the human condition as in other disciplines. Over the past three years I have come to see that to ignore the complexities surrounding spiritual issues and mental disorder is not only illogical but leads to an inability to practice holistic medicine, and to take seriously what patients care about.

The relationship between spiritual issues and mental disorder is complex but fascinating, and nearly every kind of dynamic can be seen. Spiritual concerns such as religious guilt can develop into mental disorder such as obsessive-compulsive disorder, yet spiritual issues can also be protective in stopping someone who is depressed commit suicide for religious reasons[1]. Mental disorders such as psychosis can also lead to new religious or spiritual experiences, which can be felt by patients either positively or negatively[2]. Similarly, the experience of dealing with mental health difficulties can be woven into the narrative of one's spiritual journey as a way of discovering more about oneself[3].

When seeing patients out of hours and needing to make management decisions relatively quickly, the way that one formulates a patient's difficulties, particularly if they contain explicitly spiritual or religious content, is significantly affected by the assessing clinician's own understanding of the issues. Since psychiatrists are generally less religious than their patients, this may result in failing to make a full and accurate assessment[4].

The example of religious delusions is particularly important here, because as Simms[5] has demonstrated, the nature and quality of religious beliefs and delusional beliefs are very different. Two people can have a belief with exactly the same content yet hold the belief in very different ways, with different convictions and a different relationship to the belief itself.

For example, when recently on call in an emergency department, I saw a woman who had become very distressed, was self-neglecting, thought-disordered and was acting in a bizarre and chaotic way. On further questioning, she believed that Jesus Christ would come back imminently; as a result, she was regularly leaving the house during the night, having packed all her bags, and wandering off in search of the place where Jesus would be returning. This was completely out of character for her. She was unable to explain on what basis she knew Jesus would return that night, while denying any possibility that she could be wrong or mistaken. In the context of there being a significant deterioration in her mental state, I felt that this patient's beliefs were held with delusional conviction.

Interesting, her family, who were very concerned, also believed that Jesus Christ would return, but at some unknown point in the future consistent with their Christian beliefs. They were able to appreciate that others did not share their beliefs and held their beliefs with an appropriate degree of doubt. These non-delusional features were, in my opinion, consistent with 'normal' religious belief.

This case shows the clear contrast between normal religious beliefs and religious delusions. However, without careful exploration, not merely of the content but also of the form of a belief - essential in the diagnosis of delusions[6] - the specific psychopathology and phenomenology cannot be uncovered.

This is not an isolated example. I have also seen many instances of non-religious patients presenting with very distressing spiritual beliefs leading to them seeking psychiatric help. It is clear to me that best practice requires us to have a better understanding of normal spiritual and religious beliefs, experiences and practices, in order to distinguish the pathological from the non-pathological. Without this, we are at serious risk of pathologizing normal human experience[7]. Furthermore, even if a patient is experiencing spiritual or religious symptoms as part of a mental disorder, exploring what this means to them and how it fits into their worldview can be of significant therapeutic benefit.

Besides the clinical presentation of overt religious or spiritual issues, every person with mental health problems – in common with every human being – at some time has to face deep questions of identity, meaning and purpose. This includes how to make sense of their difficulties and develop resilience in the face of a broken and painful world. In this context, spiritual issues should not be seen as something that interests a select few but rather as something that concerns all, patients and professionals alike.

We are increasingly appreciating the impact of psychological and social factors on mental disorder in addition to more traditional neurobiological concepts. Extending this to a bio-psycho-social-spiritual[8] perspective provides a much more comprehensive formulation of a patient's problems, informing diagnosis and management as well as strengthening the therapeutic relationship[9].

In conclusion, the idea that spiritual issues are unimportant or irrelevant to good psychiatric practice is, in my view, short sighted. It is at odds with a substantial research base[10] and with clinical experience, both of which indicate that spiritual concerns have a profound effect on mental health. Practising psychiatry without understanding or addressing spiritual issues cannot be good psychiatry from the perspective of either clinician or patient. As mental health becomes increasingly acknowledged in the media and society, the need for understanding and addressing our patients' spiritual issues is too important to ignore.

References

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